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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED FEB 18 1943

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

6205

State File No. \_\_\_\_\_

Registration District No. 100

Primary Registration District No. 3018

Registrar's No. 85

1. PLACE OF DEATH:

(a) County Dent  
(b) City or town Salem  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution X (Specify whether \_\_\_\_\_)  
In this community all his life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent  
(c) City or town Salem  
(If outside city or town limits, write "RURAL")  
(d) Street No. X (If rural, give location)  
(e) If foreign born, how long in U. S. A. X years

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Jan day 3  
year 1943 hour 11:30 A minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from  
1-1-43, 19\_\_\_\_, to 1-3-43, 19\_\_\_\_;  
that I last saw him alive on 1-1-43, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage  
Duration 3 days

Due to arterio sclerosis  
hypertension

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Jas D. McLead (M. D. or other) DO.  
Address \_\_\_\_\_ Date signed 1-4-43

3. (a) PRINT FULL NAME Samual Lawson Goade

3. (b) If veteran, name war X 3. (c) Social Security No. X

4. Sex male 5. Color or race W 6. (a) Single, widowed, married, divorced, married

6. (b) Name of husband or wife Bertha E Goade 6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased Dec 10 1855  
(Month) (Day) (Year)

8. AGE, 87 Years Months \_\_\_\_\_ Days 24 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Crawford Co Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business X

12. Name Booker T Goade

13. Birthplace Crawford Co Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Mickey Lica

15. Birthplace Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Bertha E Goade

(b) Address Salem Mo

17. (a) burial (b) Date thereof 1/5/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Cem

18. (a) Signature of funeral director [Signature]

(b) Address Salem Mo

19. (a) 1-4-43 (b) Jas D McLead  
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

RECEIVED

District Health Officer No. 7

District File Number 243120

Date Filed 2-15-43

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~by~~.....

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Wm. W. McRae

Licensed Embalmer No. 3806

P. O. Address Salem, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.