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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED MAR 16 1943

Registration District No. 2-3-8

Primary Registration District No. 5981-4426

Registrar's No. 12

84  
0  
0  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH

(a) County Polk

(b) City or town Fairplay - rural MOBILE CO. IN  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution none  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community none years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Polk

(c) City or town Fairplay - rural  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Lynn Ray Gould

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

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Alma Gould 6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased Sept 10 1894  
(Month) (Day) (Year)

8. AGE: Years 58 Months 5 Days 10 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace White Water Wisconsin  
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Taylor Robert Gould

13. Birthplace Boston Mass  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Alma Gould

(b) Address Fairplay Mo

17. (a) Burial (b) Date thereof 2/22/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oakland Cemetery

18. (a) Signature of funeral director Hutchison & Co

(b) Address Bolivar Missouri

19. (a) Feb 22 1943 (b) Arcelle Brown  
(If died received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 20  
year 1943 hour 4 minute 50 A.M.

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

Immediate cause of death Patient died before I reached him from what seemed to be Coronary Occlusion.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Major findings: Of operations 94 a

Of autopsy \_\_\_\_\_

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)

(a) Means of injury W. J. Myers M.D.

23. Signature Albreich Mo (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 2/27/1943

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 7

District File Number 2-43-25

Date Filed 3-4-43

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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, or by.....

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

Signed

*Chas J Ester*

Licensed Embalmer No. 4154

P. O. Address..... Bolivar 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, fact should be so stated above.