WRITE PLAINLY, WITH UNFADING [redacted] THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED JUN 12 1943

# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

18013

Do not use this space.

46 0 0

1. PLACE OF DEATH

(a) County Howell — Registration District No. 141

(b) Township Spring Creek — Primary Registration District No. 5554 — Registered No. 1

(c) or City near West Plains, Mo (d) Street No. ..... St.

(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred 1 yrs. 2 mos. 21 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME STEPHEN DALLAS GODAT

(a) Residence, No. WEST PLAINS, Mo - Rt # 3 St. ☐ (If nonresident, give city or town and State) 0

(Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Infant.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan-9-1942

7. AGE — YEARS: 1 — MONTHS: 2 — DAYS: 21 — If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Spring Creek Township West Plains Missouri O.

FATHER

13. NAME Harold Maurice Godat

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Spring Creek Twnp near West Plains, Mo

MOTHER

15. MAIDEN NAME Edna Downen

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Spring Creek Twnp near West Plains, Mo

17. INFORMANT (ADDRESS) Elmer Drumright Rt # 3 - West Plains, Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE New Liberty Cemetery DATE May-2 1943

19. FUNERAL DIRECTOR (NAME) (ADDRESS) None

20. FILED May 1- 1943 Neil Harlin Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May-1- 1943

22. I HEREBY CERTIFY, That I attended deceased from Apr-29- 1943, to May-1- 1943

I last saw him alive on Apr-29 1943 Death is said to have occurred on the date stated above, at 9:30 a.m.

The principal cause of death and related causes of importance were as follows:

tuberculosis ✓

Date of onset

Other contributory causes of importance: None

Name of operation None Date of

What test confirmed diagnosis? X-Ray Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury ....., 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) [signature], M. D.

(Address) West Plains, Mo 5/1-43

1123

(Licensed Embalmer's Statement on Reverse Side)

50M-9-19-38 I X16605

District File Number
Date Filed 643349
RECEIVED 6/7/43
District Health Officer No. 5,
District File Number 643349
Date Filed 6.7.43

Aug 20
Sept 2
Oct 3
Nov 4
Dec
Jan

31
20
11
14
25

~~bronchitis~~

Aug 20 1943
Would be 102

1943 1943
101 101
1842 1832

Lansin
Lanson
1 Aug
2 Sept
3 Oct
Nov
Dec
Jan

**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.....

Licensed Embalmer No.....

P. O. Address.....

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

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

. S. No. 2B
DM—8-21-41
PI X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 141 Primary Registration District No. 5-5-5-4 Registrar's No. 1

**1. PLACE OF DEATH**

(a) County Howell

(b) City or town Spring Creek Twp
(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 1 (Specify whether years, months or days)

In this community

**2. USUAL RESIDENCE OF DECEASED:**

(a) State (b) County

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

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

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Stephen Dallas Godat

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Jan 9 1942 (Month) (Day) (Year)

8. AGE: Years 1 Months 2 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month May 1943 Day year hour minute M.

21. I hereby certify that I attended the deceased from 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death tuberculosis of lungs - X-ray taken at at Mt. Vernon

Due to Ms. & diagnosis made there.

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature J. D. Green (M. D. ~~or other~~)

Address West Plains, Mo. Date signed 6/5/43

SUPPLEMENTARY

13 f 1

S-18013