

REGISTRATION DISTRICT NO. 2264

Primary Registration District No. 5247

Registrar's No. 50

1. PLACE OF DEATH:

(a) County Chariton  
(b) City or town Rural Salisbury, Mo.  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Chariton  
(c) City or town Rural Salisbury, Mo.  
(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 0

In this community years, months or days

3. (a) PRINT FULL NAME Sarah Amanda Gooch

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced W  
6. (b) Name of husband or wife Gideon Gooch 6. (c) Age of husband or wife if alive years 4  
7. Birth date of deceased Feb 4 1861  
(Month) (Day) (Year)

8. AGE: Years 82 Months 7 Days 28 If less than one day hr. min.

9. Birthplace Mo 0  
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business

12. Name John Whitlow

13. Birthplace Mo 0  
(City, town, or county) (State or foreign country)

14. Maiden name Melvin Sumpter

15. Birthplace Mo 0  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Monte Todd

(b) Address Salisbury, Mo

17. (a) Autopsy (b) Date thereof Oct 4 43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grain Valley Cemetery

18. (a) Signature of funeral director Geo. H. ...

(b) Address Salisbury, Mo.

19. (a) 11/1/43 (b) Rabbit  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 2  
year 1943 hour 3 minute P.M.

21. I hereby certify that I attended the deceased from Sept 15  
1942 to Oct 2 1943  
that I last saw her alive on Dec 16 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death cerebral arteriosclerosis

Due to ...  
Due to ...  
Other conditions (include pregnancy within 3 months of death) 97

Major findings: Of operations ...  
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) (e) Means of injury ...

23. Signature J. L. ... (M. D. or other) MD  
Address Salisbury, Mo Date signed 11-1-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

11-9-43

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, or by.....

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

Signed

*Geo. B. Wm. refman*

Licensed Embalmer No.

2125

P. O. Address

Salisbury Md

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.