

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 13 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37951**
Registrar's No. **121**

Registration District No. **33** Primary Registration District No. **3011**

1. PLACE OF DEATH:
(a) County **Carroll**
(b) City or town **Carrollton**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Staton Clinic**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME **Walter Goodwin**
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 **single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased **Sept. 18 1857**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
86 1 28 hr. min.

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

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER FATHER { 12. Name **James Goodwin**
13. Birthplace **Va.**
14. Maiden name **Martha Marshall**
15. Birthplace **Sweet Springs, Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Byrdie L. Cooper**
(b) Address **Waverly, Mo.**

17. (a) **Burial** (b) Date thereof **Nov. 18, 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Waverly Cemetery**

18. (a) Signature of funeral director **Willis-Marshall**
(b) Address **Carrollton, Mo.**

19. (a) **11-18-43** (b) **Miss James R. Poffey**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Lafayette 054**
(c) City or town **Waverly**
(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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Nov.** day **16th**
year **1943** hour **4** minute **45 P. M.**
21. I hereby certify that I attended the deceased from **JUNE 11-1942**
1943 to Nov 16 1943
that I last saw him alive on **Nov 16 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic interstitial Nephritis**
Duration _____

Due to _____
Due to _____
Other conditions **Chronic Myocarditis**
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: **1/3/a**
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 **Geo. J. Jones** (M. D. or other) **NO**
Address **Waverly, Mo.** Date signed **11-18-43**

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

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District File Number

Date Filed

2-10-43

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 myself.

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

Signed P. M. Marshall

Licensed Embalmer No. 2525

P. O. Address Carrollton 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.