

No. 2  
5-43  
17-39  
X3667

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED DEC 9 1943

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38667

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

Registration District No. 123

Primary Registration District No. 5709-4306

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County MO Donald

(b) City or town Goodman  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Goodman MO.  
(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) Missouri (b) County MO Donald

(c) City or town Goodman MO.  
(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 Sharon Kay Hames

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 28  
year 1943 hour 3 minute 30 P. M.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov. 25 - 1943  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov. 25, 1943, to Nov. 28, 1943, that I last saw her alive on Nov. 26, 1943, and that death occurred on the date and hour stated above.

8. AGE: Years 0 Months 0 Days 2 If less than one day  
hr. \_\_\_\_\_ min.

Immediate cause of death premature infant

Duration \_\_\_\_\_

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

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

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

10. Usual occupation \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 159

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

PHYSICIAN \_\_\_\_\_

MOTHER FATHER

12. Name Troy Hames

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

14. Maiden name Fay Brand

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

Major findings: Of operations \_\_\_\_\_

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

16. (a) Informant Troy Hames

(b) Address Goodman MO.

22. If death was due to external causes, fill in the following:

17. (a) Burial (b) Date thereof Nov. 29, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial Howard Cemetry

(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? \_\_\_\_\_

18. (a) Signature of funeral director Charles Williams

(b) Address Goodman MO.

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

(Specify type of place) \_\_\_\_\_

While at work? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature C. E. Munnis M.D. (D. or other) \_\_\_\_\_

Address Box 86, Nevada MO Date signed 12-1-43

464

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 6,

District File Number 1243-1330

Date Filed DEC 7 1943

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. *dec*

Registration District No. 193

Primary Registration District No. 4306

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

- (a) County Mc Donald
- (b) City or town Goodman  
(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 \_\_\_\_\_ (Specify whether

In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Sharon Kay James

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

4. Sex F 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 no. 25  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day, \_\_\_\_\_ min.

9. Birthplace no.  
(City, town, or county) (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 [Signature]

(b) Address [Address]

19. (a) 12-15-42 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year 1942 Minute \_\_\_\_\_ M. 8

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

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

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? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

38667