

FILED APR 10 1944
Registration District No. 4

Primary Registration District No. 4234

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

1. PLACE OF DEATH:

(a) County Iron

(b) City or town Ironton
(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 25 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Iron

(c) City or town Ironton
(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 Smith Trent Goff

3. (b) If veteran, name war no

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 15
year 1944 hour 5 minute 0 P. M.

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife Nelle T. Goff

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased June 4 1873
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 14 1944, to March 15 1944
that I last saw him alive on March 14 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy Duration 5 days

8. AGE: Years 70 Months 9 Days 11
If less than one day hr. min.

Due to Arterial Hypertension

Due to Exophthalmic goitre

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

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation mill wright

Major findings: Of operations JZal

11. Industry or business hub mill

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

12. Name Gilbert Goff

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

14. Maiden name unknown

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

16. (a) Informant Mrs. Nelle Goff

(b) Address Ironton Mo.

17. (a) burial (b) Date thereof 3-18-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Arcadia Mo.

18. (a) Signature of funeral director Norman White & Sons

(b) Address Arcadia, Ironton Mo.

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) (c) Means of injury /

23. Signature Ben W. Bull (M. D. or other) M. D.

Address Ironton, Mo. Date signed 3-17-44

1365

RECEIVED

District Health Officer No. 4
District File Number 444-3636
Date Filed 4-7-44

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 Arnell White.....

Licensed Embalmer No. 2012.....

P. O. Address Boston Mass.....

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.