DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 19 1944

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21088

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 601

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution: State Hospital No 2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 21 months (Specify whether years, months or days)

In this community 21 mos.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Carroll

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

(d) Street No. 216 No. Folger (If rural, give location)

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

If yes, name country U

3. (a) PRINT FULL NAME Sally Goodson

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex fem

5. Color or race wh

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

6. (b) Name of husband or wife —

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

7. Birth date of deceased 9 (Month) 12 (Day) 1862 (Year)

8. AGE: Years 81 Months 9 Days 0 If less than one day ..... hr. ..... min.

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

10. Usual occupation apt. house manager

11. Industry or business

FATHER
12. Name James E. Drake
13. Birthplace unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant Hospital records

(b) Address St. Joseph, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/12/44 (Month) (Day) (Year)

(c) Place: burial or cremation Carrollton, Mo.

18. (a) Signature of funeral director Heaton-Bessole & Bowman

(b) Address 319 So. 10th St.

19. (a) 6/17/44 (Date received local registrar) (b) Helen I Pickle (Registrar's signature)

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MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 12 year 1944 hour 2 minute 30 P.M.

21. I hereby certify that I attended the deceased from March 1, 1944, to June 12, 1944 that I last saw her alive on June 12, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to Senility

Due to

Other conditions Senile psychosis (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 Dora Hochdorf M.D. (M. D. or other)

Address State Hosp. No 2 St. Joseph Mo. Date signed 6/12/44

(Licensed Embalmer's Statement on Reverse Side)

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. 1710

P. O. Address St Joseph

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

If this body is not embalmed, fact should be so stated above.