

V. S. No. 2  
50M-5-42  
Rev. 5-17-39  
I X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

22647

State File No. ....

FILED JUL 10 1944  
Registration District No. 3071

Primary Registration District No. 3071

Registrar's No. 90

1. PLACE OF DEATH:  
(a) County Saline  
(b) City or town Slater  
(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 since 1908  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Saline  
(c) City or town 97  
(If outside city or town limits, write "RURAL")  
(d) Street No. 809 Grandview  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Dave James Goring  
(b) If veteran, name war v  
(c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month June day 11  
year 1944 hour 10 minute 50p M.  
21. I hereby certify that I attended the deceased from May 1  
1944 to June 11 1944  
that I last saw him alive on June 11 1944  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced, never  
(b) Name of husband or wife Mary Elizabeth Goring  
6. (c) Age of husband or wife if alive 77 years  
7. Birth date of deceased January 17 1874  
(Month) (Day) (Year)

Immediate cause of death Cancer of Larynx  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) H 7a

8. AGE: Years 70 Months 4 Days 24 hr. \_\_\_\_\_ min. \_\_\_\_\_  
9. Birthplace Kaykakee Ill  
(City, town, or county) (State or foreign country)  
10. Usual occupation Retired Plumber

Major findings: was operated at Cancer Hospital Columbia  
Of operations \_\_\_\_\_  
Of autopsy no about apr 1944  
PHYSICIAN \_\_\_\_\_  
Underline the cause of death should be charged statistically.

MOTHER FATHER

11. Industry or business \_\_\_\_\_  
12. Name John Goring  
13. Birthplace 4 Ireland  
(City, town, or county) (State or foreign country)  
14. Maiden name Eileen Warren  
15. Birthplace Ireland  
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
Date of occurrence \_\_\_\_\_  
(b) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(c) Did injury occur in or about home, on farm, in industrial place, in public place?  
(Specify type of place)  
(d) While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature C. W. Redue (M. D. or other)  
Address Slater Mo. Date signed 6-11-44

16. (a) Informant Wm J Goring  
(b) Address 809 Grandview Slater  
17. (a) burial (b) date thereof 6-14-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Slater City Cemetery  
18. (a) Signature of funeral director John J. Sadler  
(b) Address Slater Mo  
19. (a) 6-12-1944 (b) Mrs. John Goring  
(Date received local registrar) (Registrar's signature)

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

97  
2  
1

1211

RECEIVED

District Health Officer No. &

District File Number .....

Date Filed 7-8-44

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.....

Licensed Embalmer No. 3143

P. O. Address..... Slater Mrs

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.