

FILED JUL 31 1944

State File No. _____

Registration District No. 316

Primary Registration District No. 10024

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County St. Francois
 (b) City or town Farmington RURAL St. Francois
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Mo. State Hospital No. 4
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 yrs. 9 mos. 14
 (Specify whether
 In this community 2
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Louis 94
 (c) City or town Lemay 0
 (If outside city or town limits, write "RURAL") 0
 (d) Street No. Box 293, Route #11
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country 0

3. (a) PRINT FULL NAME JENNIE W. GOODE
 (b) If veteran, name war No
 (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month June day 27,
 year 1944 hour 5 minute 40 A. M.

4. Sex Female 5. Color or race W.
 6. (a) Single, widowed, married, divorced Widowed
 (b) Name of husband or wife Howard M. Goode
 (c) Age of husband or wife if alive Deceased
 7. Birth date of deceased December 3, 1857
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 20, 1944, 19____, to June 27, 1944, 19____;
 that I last saw her alive on June 26, 1944, 19____;
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
86 6 24 hr. min.

Immediate cause of death Chronic Myo-Cardial Degeneration Duration 4 yrs

9. Birthplace New Orleans Louisiana
 (City, town, or county) (State or foreign country)

Due to Arteriosclerosis - generalized 93d 1 yrs
 Due to _____

10. Usual occupation Housewife

Other conditions Severe Psychosis 4 yrs
 (Include pregnancy within 3 months of death)

11. Industry or business Kizer

Major findings: Of operations _____
 Of autopsy No autopsy.
 Underline the cause to which death should be charged statistically.

12. Name Kizer
 13. Birthplace New Orleans Louisiana
 (City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN
 15. Birthplace New Orleans Louisiana
 (City, town, or county) (State or foreign country)

16. (a) Informant Records State Hospital No. 4
 (b) Address Farmington, Mo.
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 28 1944
 (Month) (Day) (Year)
 (c) Place: burial or cremation Bellefontaine Cem., St. Alexander & Sons

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? ouis, Mo.

18. (a) Signature of funeral director 6175 Delmar St. Louis, Mo.
 (b) Address 6-30-44
 19. (a) James P. Stearns (Registrar's signature)

While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature David B. Asham (M. D. coroner)
 Address Blaine 2nd 24 Date signed 6-29-44

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

400

RECEIVED

District Health Officer No. 4
District File Number 744-4137
Date Filed 7-28-44

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.....

Not Embalmed

..... Registered Apprentice No.....

working under my personal supervision.

Signed *Red J. Miller*

Licensed Embalmer No. *3753*

P. O. Address *Farmington, 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.