

1. PLACE OF DEATH

(a) County Marion
(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Levee Hospital
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME John Franklin Goodnight

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased aug 19 1857
(Month) (Day) (Year)

8. AGE: Years 87 Months 1 Days 12 If less than one day _____ hr. _____ min.

9. Birthplace pike Co 0 Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name Harrison Goodnight

13. Birthplace pike Co 0 Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace _____ 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Elia Kinsey

(b) Address Hannibal Mo

17. (a) Burial (b) Date thereof 9-29-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Olivet Cemetery

18. (a) Signature of funeral director James O'Donnell

(b) Address Hannibal Mo

19. (a) 10-5-44 (b) R. H. Connor
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion 64
(c) City or town Hannibal Mo 3
(If outside city or town limits, write "RURAL")
(d) Street No. 1831 Valley St 4
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 26
year 1944 hour 9 minute 50 P. M.

21. I hereby certify that I attended the deceased from Aug 26 1944 to Sept 26 1944
that I last saw him alive on Sept 26 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Ca of Rectum

Due to _____
Due to H6d

Other conditions ch myocardi
(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, or farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(b) Means of injury _____

23. Signature W. J. Pulver (M. D. or other) _____
Address 1611 N. Hannibal Mo Date signed 10-4-44

1148

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

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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 Michael J. Dornell

Licensed Embalmer No. 3246

P. O. Address Hannibal 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.