

No. 2  
-5-43  
5-17-39  
X36671

FILED NOV 8 1944  
Registration District No. **282**

Primary Registration District No. **3055**

1. PLACE OF DEATH:  
(a) County **Polk**  
(b) City or town **Bolivar**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**N. Main Street**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Polk**  
(c) City or town **Bolivar**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **7 N. Main Street**  
(If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Nora Susie Goldsberry**  
(b) If veteran, name war \_\_\_\_\_  
(c) Social Security No. **500-10-0442**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Oct.** day **4** year **1944** hour **12:15** minute **A.** M.  
21. I hereby certify that I attended the deceased from **July** \_\_\_\_\_, 19**44** to **Oct 4**, 19**44**  
that I last saw her alive on **Oct 4**, 19**44** and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **widowed**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

Immediate cause of death **acute heart failure**  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

7. Birth date of deceased **Nov. 17 1891**  
(Month) (Day) (Year)  
8. AGE: Years Months Days If less than one day  
**52 10 17** hr. min.

ADDITIONAL INFORMATION REQUESTED  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

9. Birthplace **Polk County Missouri**  
(City, town, or county) (State or foreign country)  
10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_

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)  
(e) Means of injury \_\_\_\_\_

MOTHER FATHER {  
12. Name **John Acock**  
13. Birthplace **Missouri**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Ellen Lusk**  
15. Birthplace **Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Miss Omelene Goldsberry**  
(b) Address **Bolivar, Mo.**  
17. (a) **Burial** (b) Date thereof **Oct. 9, 1944**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Slagle's Cemetery**

18. (a) Signature of funeral director **Hutcheson-Turpin & Co.**  
(b) Address **Bolivar, Mo.**  
19. (a) **Oct 9 1944** (b) **Alice Palen**  
(Date received local registrar) (Registrar's signature)

Signature **D. M. C. [unclear]** (M. D. or other) \_\_\_\_\_  
Address **Bolivar Mo** Date signed **10-9-44**

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

1294

RECEIVED

Dis. No. 7

Dis. No. 44-1216

Date Filed 11-16-44

**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

working under my personal supervision.

Registered Apprentice No.

Signed

Licensed Embalmer No. 3053

P. O. Address Bolivar, 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Nov  
Registrar's No. 29

Registration District No. 282 Primary Registration District No. 3055

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

1. PLACE OF DEATH:

(a) County Polk

(b) City or town Bellevue  
(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 \_\_\_\_\_ years, months or days (Specify whether \_\_\_\_\_)

3. (a) PRINT FULL NAME Mrs. Lucie Goldsberry

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year

7. Birth date of deceased Nov. 17 (Month) (Day) (Year)

8. AGE: Years 52 Months 10 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

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

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

20. DATE OF DEATH: Month Oct Day 17 Year 1974 hour \_\_\_\_\_ minute \_\_\_\_\_ M. \_\_\_\_\_

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_ 19 \_\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death acute heart failure Duration \_\_\_\_\_

Due to chronic myocarditis

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 93d

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

23. Signature Doyhemman (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

MEDICAL CERTIFICATION

SUPPLEMENTAL

PHYSICIAN

Underline the cause to which death should be charged statistically.

35061