

FILED JAN 8 1945

Registration District No. 2-3

Primary Registration District No. 43-83-5855

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Madaway
 (b) City or town Barnard
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: None
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution None
 (Specify whether
 In this community Several years
 years, months or days)

3. (a) PRINT FULL NAME Elizabeth Bell Goff
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M
 6. (b) Name of husband or wife Emmett Goff 6. (c) Age of husband or wife if alive 64 years
 7. Birth date of deceased Sept 22 1885
 (Month) (Day) (Year)

8. AGE: Years 59 Months 2 Days 17 If less than one day hr. _____ min. _____

9. Birthplace Marionville Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER
 12. Name James B. Burr
 13. Birthplace Unknown Canada
 (City, town, or county) (State or foreign country)
 14. Maiden name Margaret Murty
 15. Birthplace Unknown Canada
 (City, town, or county) (State or foreign country)

16. (a) Informant Lee Goff

(b) Address Barnard Mo.

17. (a) Burial (b) Date thereof 12-13-44
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill Marionville

18. (a) Signature of funeral director Camyrell General Home

(b) Address Marionville Mo.

19. (a) 12/13/1944 (b) Mrs. Peter Hockenthal
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Madaway
 (c) City or town Barnard
 (If outside city or town limits, write "RURAL")
 (d) Street No. Rural
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 9
 year 1944 hour 1 minute 30 P. M.

21. I hereby certify that I attended the deceased from October 25
1944 to December 8 1944;
 that I last saw her alive on December 8 1944;
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration 8 wks.
 Due to Cardio-Vascular-Renal disease 2 Years

Due to _____
 Other conditions 13/10
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

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?

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

23. Signature M. A. Burr (M. D. or other) D.O.
 Address Marionville Mo. Date signed 12/13/44

1341

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

0711

JAN 26 1945

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.....

Marjorie Luke Campbell, Registered Apprentice No. *360*
working under my personal supervision.

Signed *William Campbell*
Licensed Embalmer No. *2620*

P. O. Address *Marquill 71*

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.

2B
43
36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan

Registration District No. 2531

Primary Registration District No. 5855

Registrar's No. _____

1. PLACE OF DEATH:

(a) County nodaway

(b) City or town Rural White Cloud Twp.
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County nodaway

(c) City or town Burned Rural
(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 _____

3. (a) PRINT FULL NAME Elizabeth B. Gaff

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Sept 22 1894
(Month) (Day) (Year)

8. AGE: Years 59 Months _____ 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 housewife

12. Name B. Burr

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

14. Maiden name Margaret Murray

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

16. (a) Informant Lee Gaff

(b) Address Burned, Mo

17. (a) _____ (Burial, cremation, or removal)

(b) Date thereof 12-13-44 (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Margaret, Mo

(b) Address _____

19. (a) _____ (Data received local registrar)

(b) Guy Barber (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 9
Year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature M. C. Den (M. D. or other) 1944

Address Maitland, Mo Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

MOTHER FATHER

S-41760 1944