S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

9663

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 9 1945
128

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

Primary Registration District No. 2000

Registrar's No. 247

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1464 South National
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 17 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

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

(d) Street No. 1464 S.National
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME James Chrismon Gooch

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife UNK.

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

7. Birth date of deceased Sept. (Month) 13, (Day) 1859 (Year)

8. AGE: Years 85 Months 6 Days 9 If less than one day hr. min.

9. Birthplace Waynesburg, ~~Ky.~~ (City, town, or county) Kentucky (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Wilson Gooch
13. Birthplace ~~Ky~~ UNK. (City, town, or county) Kentucky (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace ~~Ky~~ UNK. (City, town, or county) Kentucky (State or foreign country)

16. (a) Informant Mrs. W. E. Gooch
(b) Address 1464 S.National, Spfd., Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-23, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Hopedale

18. (a) Signature of funeral director W. L. Dunn
(b) Address Springfield, Mo.

19. (a) 3-23-45 (Date received local registrar) (b) Dr W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 22
year 1945 hour 4 minute 35A. M.

21. I hereby certify that I attended the deceased from March 14, 1945, to March 15, 1945, that I last saw him alive on March 15, 1945, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death ~~Cerebral~~ Cerebral hemorrage	
Due to Arteriosclerosis	
Due to	
Other conditions age (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? (Specify type of place)
While at work? (e) Means of injury

23. Signature J. G. Robertson (M. D. or other)
Address Spfd., Mo. Date signed 3/22-45

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(Licensed Embalmer's Statement on Reverse Side)

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. Charles W. McCallum

Licensed Embalmer No. 2891

P. O. Address.....

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.