

FILED APR 17 1945

Registration District No. 199

Primary Registration District No. 4311

Registrar's No. 4

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

1. PLACE OF DEATH:

(a) County Macon

(b) City or town Callao
(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 years, months or days)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon

(c) City or town Callao Mo 61
(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 Nathanial Goodrich

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 24
year 1945 hour 4 minute 30 P M.

4. Sex Male 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

7. Birth date of deceased 9-24-1864
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Mar 24 1945 to Mar 26 1945
that I last saw him alive on Mar 26 1945
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>80</u>	<u>6</u>	<u>0</u>	hr. _____ min.

Immediate cause of death Myocarditis

Due to _____

Due to _____

9. Birthplace Madison Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Merchant

11. Industry or business _____

Other conditions Drupry
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy no 932

MOTHER FATHER

12. Name Rene S. Goodrich

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

14. Maiden name Martha Woodfield

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Roland Goodrich
(b) Address Callao Mo

17. (a) Burial (b) Date thereof 3-26-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Callao

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? _____

(c) Place: burial or cremation Callao

18. (a) Signature of funeral director R. S. Edwards
(b) Address 13 W. 7th St. Mo

19. (a) Mar 28, 1945 (b) W. J. Allen
(Date received local registrar) (Registrar's signature)

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

23. Signature W. J. Allen (M. D. or other) _____
Address New Dinkler St Date signed Mar 26 1945

APR 20 1945

RECEIVED
District Health Officer No. 10
District File Number 4-45-674
Date Filed APR 13 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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *H. J. Edwards*
Licensed Embalmer No. 1961
P. O. Address *Brewer 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.