S. No. 2
M—a-43
. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 10 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24512

Registration District No. 340 — Primary Registration District No. 4503 — Registrar's No. 76

1. PLACE OF DEATH:
(a) County: Stoddard
(b) City or town: Bernie (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home (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: Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Stoddard
(c) City or town: Bernie (If outside city or town limits, write "RURAL") 103
(d) Street No. Mo. (If rural, give location) 1 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME: John Goforth
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: married
6. (b) Name of husband or wife: Cora Goforth
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: May (Month) 15 (Day) 1870 (Year)
8. AGE: Years 75 | Months 1 | Days 14 | If less than one day ____ hr. ____ min.
9. Birthplace: Mo (City, town, or county) (State or foreign country)
10. Usual occupation: Farming
11. Industry or business ____
FATHER 12. Name: J. Goforth
FATHER 13. Birthplace: Ky (City, town, or country) (State or foreign country)
MOTHER 14. Maiden name: Margret Robinson
MOTHER 15. Birthplace: Tenn (City, town, or county) (State or foreign country)
16. (a) Informant: Cora Goforth
(b) Address: Bernie Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: July 1-45 (Month) (Day) (Year)
(c) Place: burial or cremation: Bernie
18. (a) Signature of funeral director: Landers F. H.
(b) Address: Campbell Mo
19. (a) 7-2-45 (Date received local registrar) (b) Cardie Miller (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: June day: 29 year: 1945 hour: 3 minute: a.m.

21. I hereby certify that I attended the deceased from April 11, 1945 to June 29, 1945 that I last saw him alive on 6-29, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Cancer of Face — Duration: 4 months
Due to ____
Due to ____
Other conditions (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: F. O. Kelley M.D.
Address: Bernie Mo Date signed: 7/2/45

1163 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 745-887
Date Filed 7-6-45

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 E. W. Landers

Licensed Embalmer No. 2289

P. O. Address Carrollton 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.