

No. 2
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5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3476**
Registrar's No. **1**

FILED FEB 7 1946

Registration District No. **244** Primary Registration District No. **5834**

1. PLACE OF DEATH:
 (a) County **Newton**
 (b) City or town **Sarcoxie Rt. #1 Rural, Marion**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Rt. #1 Sarcoxie**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **36 Years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Newton**
 (c) City or town **Rural**
(If outside city or town limits, write "RURAL")
 (d) Street No. **Sarcoxie Rt. #1**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Lucy Alice GOEN**
 3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **January**, day **23**, year **1946**, hour **3**, minute **30 a.m.**
21. I hereby certify that I attended the deceased from **November 1, 1944** **to** **January 23, 1946**
 that I last saw her alive on **January 22, 1946** 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 **I. N. Goen** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **October 31, 1871**
(Month) (Day) (Year)

Immediate cause of death **Cardiac & Respiratory Failure**
 Duration **3 mo.**

8. AGE: Years **74** Months **2** Days **21** If less than one day **4** hr. **---** min.

Due to **Mitral Stenosis**
Chronic Bronchitis

9. Birthplace **Conway Co., Arkansas**
(City, town, or county) (State or foreign country)

Due to _____
 Other conditions (Includes pregnancy within 3 months of death) _____

10. Usual occupation **Housewife**
11. Industry or business **none**

Major findings: Of operations **92%**
 Of autopsy _____

12. Name **Mr. John Eoff**
13. Birthplace **Unknown Tennessee**
(City, town, or county) (State or foreign country)
14. Maiden name **Anna Sanders**
15. Birthplace **Searcy Co., Arkansas**
(City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant **Bert Goen**
 (b) Address **Diamond Missouri**

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____

17. (a) Burial (b) Date thereof **1 25 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Sarcoxie Cemetery**

(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? _____

18. (a) Signature of funeral director **Ed C. Ulmer**
 (b) Address **1208 S. Garrison Ave.**
19. (a) Jan 21-46 (b) **ma. Alice Parnell**
(Date received local registrar) (Registrar's signature)

While at work _____ (Specify type of place) (c) Means of injury _____
23. Signature **[Signature]** (D.O. or other) **D.O.**
 Address **SARCOXIE, MISSOURI** Date signed **1/23/46**

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

1671

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

John Stephen Penn
Licensed Embalmer No. *4194*
P. O. Address: *Carthage, N*

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.