

FILED MAY 9 1946

2 1946 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 93

Primary Registration District No. 5342

Registrar's No. 33

1. PLACE OF DEATH:

(a) County Dale
(b) City or town Pennsboro
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
No Street 1
(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 38 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dale
(c) City or town Pennsboro
(If outside city or town limits, write "RURAL")
(d) Street No. None
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JOHN FELIX GODFREY

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Carrie B. Lewis 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 15, 1860
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
85 8 30 _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business Farm

MOTHER FATHER { 12. Name Abraham J. Godfrey
13. Birthplace Iowa
(City, town, or county) (State or foreign country)
14. Maiden name Mary Ann Lewis
15. Birthplace Iowa
(City, town, or county) (State or foreign country)

16. (a) Informant Albert H. Godfrey

(b) Address South Greenfield Mo

17. (a) Burial (b) Date thereof 4-16-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pennsboro, Mo.

18. (a) Signature of funeral director Sam E. Senanney

(b) Address Greenfield, Mo.

19. (a) 4-19-1946 (b) Geo. A. Deer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 14
year 46 hour 6 P.M. minute _____ M.
21. I hereby certify that I attended the deceased from 1-1-46
_____ 19____ to 4-14 1946

that I last saw him _____ alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death myocardial failure

Due to _____
Due to _____

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

Major findings: 2000
Of operations _____
Of autopsy _____

Duration
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 St. Rawan (M. D. or other) _____
Address Greenfield Mo Date signed 4-16-46

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 *Sam E. Senecey Jr.*

Licensed Embalmer No. *40990*

P. O. Address, *Greenfield M.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. May
Registrar's No. 331

Registration District No. 93 Primary Registration District No. 5342

1. PLACE OF DEATH:

(a) County Dade
(b) City or town Pennshoro
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME

John - F. Godfrey
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased: July (Month) 1946 (Year)

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

9. Birthplace: _____ (City, town, or county) _____ (State or foreign country) Iowa

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

{ 14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4-14-1946 (Date received local registrar) 1. Geo L. Weir (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1946 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Duration

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 _____

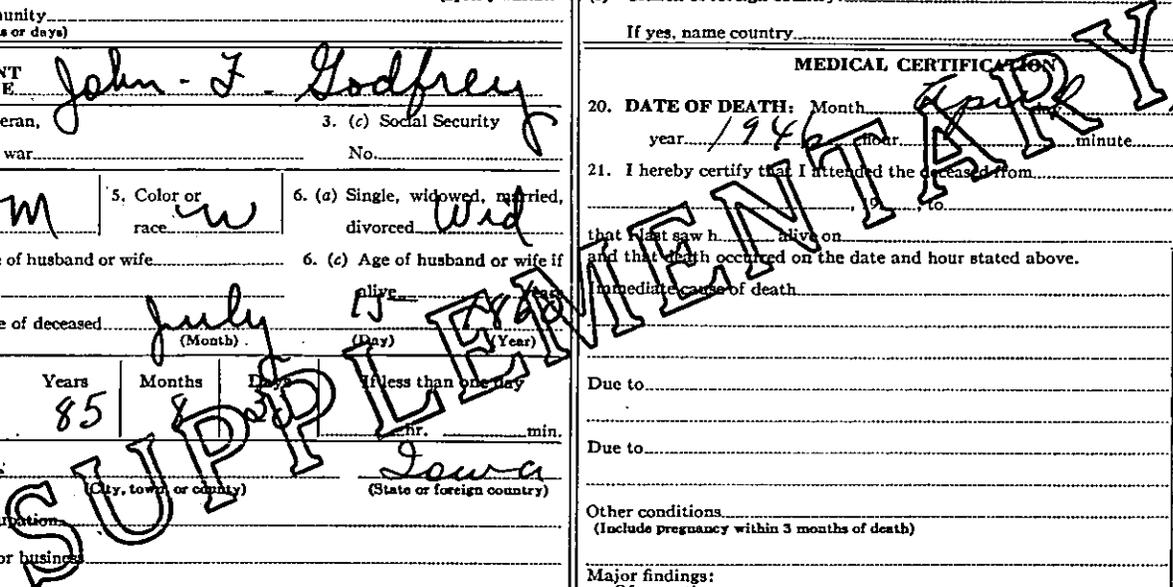
(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

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

23. Signature _____ (M. D. or other)

Address _____ Date signed _____



RECORD - MAKE A PERMANENT RECORD

12086