

FILED JAN 14 1947

Registration District No. **75**

Primary Registration District No. **5301**

Registrar's No. **98**

1. PLACE OF DEATH:

(a) County Clinton
 (b) City or town Platt
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 78 yrs years, months or days

3. (a) PRINT FULL NAME MARGARET-ELIZABETH-GOLDEN

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Morris Golden 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased FEB - 28 - 1868
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>9</u>	<u>20</u>	hr. _____ min. _____

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

10. Usual occupation Housekeeping

11. Industry or business _____

MOTHER FATHER { 12. Name H. B. Kendall
 13. Birthplace Virginia
 (City, town, or county) (State or foreign country)
 14. Maiden name Nancy Jane Kerns
 15. Birthplace Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant Wynnow Kendall

(b) Address Stewartville

17. (a) _____ (b) Date thereof Dec. 19 - 1946
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Funerary Chapel, Century

18. (a) Signature of funeral director F. S. Gou

(b) Address Stewartville Mo.

19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clinton
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. Osborn R.F.D.
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 18
 year 1946 hour 7 minute 30 A.M.

21. I hereby certify that I attended the deceased from July 3
1946 to Dec. 18, 1946
 that I last saw her alive on Dec. 18, 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death Stroke

Duration _____
 Due to Extremities Gross over without body

Due to Accidental house fire

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. S. Gule (M. D. or other) _____

Address Osborn Mo. Date signed 1/18/46

ADDITIONAL SUPPLEMENTARY INFORMATION

25

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

DISTRICT HEALTH OFFICER
Cameron, Mo.

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..... *J. G. Lyon*

Licensed Embalmer No. *Stewart*

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.

2B
45
43880

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

State File No. Jan 98
Registrar's No. 98

Registration District No. 75

Primary Registration District No. 5301

1. PLACE OF DEATH:

(a) County Clinton Platt

(b) City or town Clinton Platt
(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 Margaret C. Golden

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race w

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Feb 28
(Month) (Day) (Year)

8. AGE: Years 78 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 12-19-47 (b) Mrs. Willie Jenkins
(Date received local registrar) (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 _____ Day _____
year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, 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) Accidental

(b) Date of occurrence Dec-17-1946

(c) Where did injury occur? Osborn funeral at home
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Not home in Rural district?

While at work? yes (Specify type of place) (c) Means of injury Fire

23. Signature W.S. Gale (M. D. or other) _____

Address Osborn Mo Date signed _____

SUPPLEMENTARY

39991