

S. No. 2
M-8-43
5-17-39
P-1 X37823

THE STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8129

FILED APR 1 1947

Registrar's No. 112

Registration District No. 77

Primary Registration District No. 3008

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

4
1
2

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 29 1/2 hrs
(Specify whether _____)

In this community same
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Marion

(c) City or town Waywood
(If outside city or town limits, write "RURAL")

(d) Street No. 2
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME ANNA GOEHL

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

7. Birth date of deceased OK 1872
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 16 year 1947 hour _____ minute 8 25 M.

21. I hereby certify that I attended the deceased from 3/6 1947 to 3/16 1947 that I last saw her alive on 3/16 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy

Duration _____

8. AGE: Years 75 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation work

11. Industry or business home

MOTHER FATHER { 12. Name OK

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

14. Maiden name OK

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

16. (a) Informant Hospital records

(b) Address Fulton Mo

17. (a) Removal (b) Date thereof 3-16-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ewing Mo

18. (a) Signature of funeral director Hallpike Funeral Home
(b) Address 7 N. 6th St. Fulton Missouri

19. (a) 3-21-1947 (b) Joan Monahan
(Date received local registrar) (Registrar's signature)

Due to _____

Due to _____

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

Major findings: Of operations g b p

Of autopsy _____

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)

23. Signature W Caldwell (M. D. or other) W Caldwell
Address Fulton Mo Date signed 3/16/47

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

38

Date Filed 3-31-47

District File Number

District Health Officer No. 9,

RECEIVED

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 Wenzel C. Browning

Licensed Embalmer No. 2724

P. O. Address Fulton Md

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.