

1. PLACE OF DEATH:

(a) County Marion

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

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

(d) Length of stay: In hospital or institution 2 WKS
(Specify whether years, months or days)

In this community _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ralls 87

(c) City or town Saxerton 0
(If outside city or town limits, write "RURAL")

(d) Street No. Rural 0
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No) 1
If yes, name country _____

3. (a) PRINT FULL NAME Frank A. Goy

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 Single ()

6. (b) Name of husband or wife _____

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

7. Birth date of deceased June 1, 1870
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
76	9	9	hr. _____ min.

9. Birthplace Barry ILL 1
(City, town, or county) (State or foreign country)

10. Usual occupation laborer

11. Industry or business _____

12. Name Stephen J. Goy

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

14. Maiden name Mary Parks

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

16. (a) Informant Mrs. Pannina Goy

(b) Address Saxerton Mo

17. (a) Burial (b) Date thereof March 12, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grandview Burial Park

18. (a) Signature of funeral director James O'Connell

(b) Address Haverhill Mo

19. Mar 14 1947 (b) Dr. E. M. Luke
(Approved local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10
year 1947 hour _____ minute 2:20 P.M.

21. I hereby certify that I attended the deceased from Nov 8, 1947, to Nov 10, 1947
that I last saw him alive on Nov 10, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Ischemic Heart Disease Duration 3 1/2 hrs

Due to _____

Due to _____

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

Major findings:
Of operations _____ 108
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)
Means of injury 5

23. Signature A. B. Blue (M. D. or other) _____
Address Haverhill Mo Date signed 3-12-47

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

6
3
4

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. 497
working under my personal supervision.

Signed H. M. O'Connell

Licensed Embalmer No. 3889

P. O. Address Hannibal, 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.