S. No. 2
0M—2-43
v. 5-17-39
I X35897

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 17 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20751

Registration District No. 137 Primary Registration District No. 4218 Registrar's No. 136

1. PLACE OF DEATH:
(a) County Henry
(b) City or town Calhoun
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Community Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 Days (Specify whether)
In this community (years, months or days) 76

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Henry
(c) City or town Calhoun
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Lillian Goodrich
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 Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Oct (Month) 30 (Day) 1857 (Year)

8. AGE: Years 89 | Months 7 | Days 10 | If less than one day ___ hr. ___ min.

9. Birthplace Fort Atkinson (City, town, or county) Wis. (State or foreign country)
10. Usual occupation Home keeper
11. Industry or business

MOTHER FATHER
12. Name E D Goodrich
13. Birthplace N.Y. (City, town, or county) (State or foreign country)
14. Maiden name Lucinda Goodrich
15. Birthplace N.Y. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. F C Goodrich
(b) Address Calhoun Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-11-47 (Month) (Day) (Year)
(c) Place: burial or cremation Calhoun Cemetery
18. (a) Signature of funeral director [illegible]
(b) Address Calhoun Mo
19. (a) 6-11-47 (Date received local registrar) (b) R R Kenny (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 9 year 47 hour 2 minute — P.M.
21. I hereby certify that I attended the deceased from 3-31 19 47, to 6-9 19 47, that I last saw her alive on 6-8 19 47 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardiac decompensation	8
Due to: Chronic myocarditis	3
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? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature Ray B Jordan (M. D. or other)
Address Windsor Mo Date signed 6-9-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 5-47-74
Date Filed 6-26-47

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 my self

....., Registered Apprentice No.....,

working under my personal supervision.

Signed J. R. Massey

Licensed Embalmer No. 3502

P. O. Address Calhoun, Miss.

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.