S. No. 2
I—1/47
. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 14 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 23361

Registration District No. 38 | Primary Registration District No. 3006 | Registrar's No. 212

1. PLACE OF DEATH:
(a) County: Boone
(b) City or town: Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wilhite Convalescent Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 1 Month (Specify whether years, months or days)
In this community:

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

3. (a) PRINT FULL NAME: THOMAS OTTO GOFF
3. (b) If veteran, name war: None
3. (c) Social Security No.: None
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: 12 (Month) - 23 (Day) - 1862 (Year)

8. AGE: Years 84 | Months 7 | Days 13 | If less than one day: hr. min.
9. Birthplace: Morgan County (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: At Home
11. Industry or business:
MOTHER FATHER
12. Name: THOmas Goff
13. Birthplace: Benton County (City, town, or county) Missouri (State or foreign country)
14. Maiden name: Lydia Boyd
15. Birthplace: Miller County (City, town, or county) Missouri (State or foreign country)
16. (a) Informant: M.T. Goff
(b) Address: Route 2, Hallsville, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8-7-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Union Cemetery
18. (a) Signature of funeral director: Parker Funeral Service
(b) Address: Columbia, Mo.
19. (a) 8-8-47 (Date received local registrar) (b) Mrs P E Palmer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Aug. day: 6 year: 1947 hour: 9 minute: 40 A.M.
21. I hereby certify that I attended the deceased from July 12, 1947, to Aug 6, 1947, that I last saw him alive on Aug 5, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchopneumonia
Due to: Chronic Nephritis
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations: 3/B
Of autopsy:

Duration

PHYSICIAN
Underline the cause of 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? (Yes or No) Means of injury:
23. Signature: Robert H. Simpson (M. D., or other)
Address: Columbia Mo Date signed: 8-8-47

Jefferson City Printing Co.
(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,

District File Number AUG 13 1947
Date Filed

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.....

Licensed Embalmer No. 4132

P. O. Address Columbia, 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.