S. No. 2
DM—2-43
v. 5-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 15 1947

Registration District No. 107

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37602

Primary Registration District No. 542

Registrar's No. 257

1. PLACE OF DEATH:
(a) County: Dunklin
(b) City or town: Gobler Rural (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home Rural Route 1 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ In this community: Life-time (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Dunklin
(c) City or town: Gobler Rural (If outside city or town limits, write "RURAL")
(d) Street No.: Rural Route 1 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: WILLIAM FRANKLIN GOAD
3. (b) If veteran, name war: X
3. (c) Social Security No.: X

4. Sex: Male 0
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: X
6. (c) Age of husband or wife if alive: X years
7. Birth date of deceased: December (Month) 22, (Day) 1867 (Year)

8. AGE: Years 79 | Months 11 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace: Wayne, Co., (City, town, or county) 0 Missouri (State or foreign country)
10. Usual occupation: Retired
11. Industry or business: X

FATHER
12. Name: John Goad
13. Birthplace: Wayne, Co., (City, town, or county) 0 Missouri (State or foreign country)

MOTHER
14. Maiden name: Sarah Adams
15. Birthplace: Wayne, Co., (City, town, or county) 0 Missouri (State or foreign country)

16. (a) Informant: Coy Garrett
(b) Address: Gobler, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11/28/47 (Month) (Day) (Year)
(c) Place: burial or cremation: Kennett, Missouri
18. (a) Signature of funeral director: H.S.Smith Funeral Home
(b) Address: Caruthersville, Mo.
19. (a) 11-28-1947 (Date received local registrar) (b) Earl Husband (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 26 year 1947 hour 4 minute 25 P.M.
21. I hereby certify that I attended the deceased from Nov 24, 1947, to Nov 26, 1947 that I last saw him alive on Nov 26, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Congestive heart failure
Due to: Arteriosclerosis
Due to: Diabetes
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations: 0
Of autopsy:

Duration

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: Chester R. Peck (M. D. or other) M.D.
Address: 115 St. Francis St. Date signed: Nov 28, 1947

(Licensed Embalmer's Statement on Reverse Side) Kennett Mo

RECEIVED
District Health Office No. 2,
District File Number 1847-1542
Date Filed 12-4-47

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 William D. Dike, Registered Apprentice No. 440, working under my personal supervision.

Signed James A. Osburn

Licensed Embalmer No. 4185

P. O. Address Caruthersville, 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.