. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 11 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29325

Registration District No. 99 Primary Registration District No. 4168 Registrar's No. 53

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

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Dekalb 32
(c) City or town Stewartsville Mo. 3
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? no. ~~(Yes or No)~~
If yes, name country

3. (a) PRINT FULL NAME Joseph Golledge
3. (b) If veteran name war — 3. (c) Social Security No. —
4. Sex Mo 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ella Golledge 6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased Oct (Month) 24 (Day) 1869 (Year)

8. AGE: Years 78 Months 10 Days 24 If less than one day hr. min.
9. Birthplace Stockton (City, town, or county) Canada Do (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER
12. Name John Golledge
13. Birthplace — (City, town, or county) Canada (State or foreign country)
MOTHER
14. Maiden name Mary Ann Smith
15. Birthplace — (City, town, or county) England (State or foreign country)
16. (a) Informant Fred Golledge
(b) Address 11001 E. 24 Independence Mo
17. (a) B (Burial, cremation, or removal) (b) Date thereof 9 20 48 (Month) (Day) (Year)
(c) Place: burial or cremation Stewartsville, Mo.
18. (a) Signature of funeral director Lyon Funeral Home
(b) Address Stewartsville, Mo
19. (a) 10-5-48 (Date received local registrar) (b) R Davidson (Registrar's signature) X D

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 18
year 1948 hour 5 minute 40 P.M.
21. I hereby certify that I attended the deceased from May, 1947 to Sept 18, 1948
that I last saw him alive on: Sept 18, 1948
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Embolus	4 days
Due to Cerebral Thrombosis	4 months ago
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 83B
Of autopsy

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) 2
While at work? (e) Means of injury
23. Signature Dr. Harold Fowler (M. D. or other) DA
Address Maysville Mo Date signed 9-19-48

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

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 W. E. Summerfield

Licensed Embalmer No. 3007

P. O. ~~Address~~ Stewartsville, 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.