

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39933**
Registrar's No. **39**

FILED DEC 5 1949

BIRTH NO. _____ REG. DIST. NO. **347** PRIMARY REG. DIST. NO. **6160**

104
9

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

1. PLACE OF DEATH a. COUNTY Stone			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY Stone		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL Antscreek		c. LENGTH OF STAY (In this place) Life	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL Antscreek		d. STREET ADDRESS (If rural, give location) RURAL Antscreek
3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Albert c. (Last) Goodwin			4. DATE OF DEATH (Month) (Day) (Year) Nov 7 1949		
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Nov 28-1860	9. AGE (In years last birthday) 88	IF UNDER 1 YEAR Months 11 Days 21
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Medford ILL.		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME Valenston		14. NAME OF HUSBAND OR WIFE BRIDGET ANN Goodwin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Earl Dotson ADDRESS Reeds Spring		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, assthenia, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial Asthma ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 70+ yrs DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Age		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 11-6-1949 to 12-4-49 , that I last saw the deceased alive on 11-10-1949 , and that death occurred at 7:30 a.m. , from the causes and on the date stated above.					
23a. SIGNATURE W. Platter (Degree or title) MD			23b. ADDRESS		23c. DATE SIGNED 11-7-49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov 8-1949	24c. NAME OF CEMETERY OR CREMATORY Snow Cemetery	24d. LOCATION (City, town, or county) (State) Barryville Arkansas		
DATE REC'D BY LOCAL REG. Nov. 7-49	REGISTRAR'S SIGNATURE Lena Murray		317 25. FUNERAL DIRECTOR'S SIGNATURE C. J. Moss		ADDRESS Reeds Spring Mo

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was not embalmed

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.....

..... Student Embalmer No.

working under my personal supervision.

Signed.....

Signed.....
Student Embalmer

..... Licensed Embalmer No.....

P. O. Address.....

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.