

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

16048

1. PLACE OF DEATH

County Randolph

Registration District No. 735

Township Moberly

Primary Registration District No. 3034

City Moberly

(No. 127 Bedford)

File No. _____

Registered No. 103

St. 3rd Ward

2. FULL NAME

Keaton L Goodnight

(a) Residence. No. 127 Bedford St. 030 Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Annie Goodnight

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Sept 24 1860

7. AGE

YEARS 66

MONTHS 8

DAYS —

IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

My Goods Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer.

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Mo

10. NAME OF FATHER

Abraham Goodnight

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo

12. MAIDEN NAME OF MOTHER

Susan Riley

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo

14.

INFORMANT (Address)

Mrs Annie Goodnight
Moberly Mo

15.

FILED 5-25-27 19 27

Chas. S. Fleming

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

May 23rd 1927

17.

I HEREBY CERTIFY That I attended deceased from May 23rd 1927 to May 23rd 1927 that I last saw him alive on May 23rd 1927, and that death occurred, on the date stated above, at 12:00 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Fracture of Skull at base of brain caused by fall.

(duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY)

186 W
194 B

(duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) W. H. Rusten

M. D.

5-25th 1927 (Address) Moberly Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Moberly Mo

5-25th 1927

20. UNDERTAKER

Mahaw and Low

ADDRESS

Moberly Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

NOV 25 1927

