REG'D SEP 20 1939

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

29254
Do not use this space.

1. PLACE OF DEATH
(a) County Henry 2 Registration District No. 347
(b) Township Bogard 1 Primary Registration District No. 3485 Registered No.
(c) City (d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 365 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mariah Elizabeth Goodrum
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 25 1857

7. AGE — YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
82	5	0	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. Housewife
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

FATHER
13. NAME Robert Wilson
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Maryland

MOTHER
15. MAIDEN NAME Mary Hefner
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

17. INFORMANT (ADDRESS) Jno Wilson Creighton Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Wright Mo DATE 7-27-39

19. FUNERAL DIRECTOR (ADDRESS) Robert Arnold Creighton Mo

20. FILED 8-30 1939 Dr J R Hampton Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 25 1939

22. I HEREBY CERTIFY That I attended deceased from July 20 1939 to July 25 1939
I last saw her alive on July 21 1939 Death is said to have occurred on the date stated above, at 4-30 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Fall-struck on shoulder	
no bones broke	
Hypostatic Pneumonia.	

Other contributory causes of importance:
None

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Fall Date of injury 7/17 1939
Where did injury occur? At home (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury Fall
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) L. L. Smith M.D., M. D.
312 (Address) Creighton Mo

(Licensed Embalmer's Statement on Reverse Side)

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.

RECEIVED
District Health Officer No. 7,
District File Number 7-39-1791
Date Filed 9-7-39

STATEMENT BY LICENSED EMBALMER

I, ..., Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

.....L. E.....

No.....or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)