

FD APR 14 1943 137  
Registration District No. **137**

Primary Registration District No. **3023**

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

1. PLACE OF DEATH:

(a) County Henry

(b) City or town Clinton  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
113 N Carter  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community 50 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Henry

(c) City or town Clinton Mo  
(If outside city or town limits, write "RURAL.")

(d) Street No. 113 N Carter  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME SARAH JANE Goff

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 19  
year 1943 hour 1 minute 11 M.

21. I hereby certify that I attended the deceased from 3/16 1943, to 3/19 1943  
that I last saw her alive on 3/16 1943  
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife Robert Goff 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 25 1887  
(Month) (Day) (Year)

Immediate cause of death: Don't know  
Atherosclerosis  
Due to Hypertension  
Senility  
Due to Arthritis

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years 85 Months 10 Days 1  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) W. Va

10. Usual occupation House work

11. Industry or business \_\_\_\_\_

12. Name Sam Bell

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) W. Va

14. Maiden name Don't know

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Don't know

Major findings: None

Of operations \_\_\_\_\_

Of autopsy None

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Wm & B Rainey

(b) Address Clinton Mo

17. (a) Burial (b) Date thereof 3/26/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Combs Cem

18. (a) Signature of funeral director Consolus Peeler

(b) Address Clinton Mo

19. (a) March 19 1943 (b) Georgia Kitchen  
(Date received local registrar) (Registrar's signature)

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) \_\_\_\_\_ (Specify type of injury) \_\_\_\_\_

23. Signature Ed. E. Peeler (M. D. or other)

Address Clinton Mo Date signed 3/19/43

RECEIVED  
 District Health Office No. 71  
 District File Number 3-43-109  
 Date Filed 4-13-43

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..... *J. E. Conzelmann* .....

Licensed Embalmer No. *1891* .....

P. O. Address..... *Antonia, 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.