S. No. 2
—8-43
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 12 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30355

Registration District No. 73 | Primary Registration District No. 3014 | Registrar's No. 108

1. PLACE OF DEATH:
(a) County Clay (b) City or town Liberty
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: His Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Clay 24
(c) City or town Liberty 2
(If outside city or town limits, write "RURAL")
(d) Street No. South Main 1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME THOMAS GOODWIN
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Male 2 | 5. Color or race Negro | 6. (a) Single, widowed, married, divorced Single 40
6. (b) Name of husband or wife ____
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased ____ (Month) ____ (Day) 1883 (Year)

8. AGE: Years 62 | Months ____ | Days ____ | If less than one day ____ hr. ____ min.

9. Birthplace Hart Co. Ky. (City, town, or county) (State or foreign country)
10. Usual occupation Laborer
11. Industry or business ____

MOTHER FATHER
12. Name Daniel Goodwin
13. Birthplace ____ Ky. (City, town, or county) (State or foreign country)
14. Maiden name Amanda Smith
15. Birthplace ____ Mo. (City, town, or county) (State or foreign country)

16. (a) Informant James Goodwin
(b) Address Forest City Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Fairview Liberty, Mo.
18. (a) Signature of funeral director Ernest Gardner Co.
(b) Address Liberty, Mo.
19. (a) Oct 1 45 (Date received local registrar) (b) Minnie Haynes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 28
year 1945 hour 2 minute — A.M.

21. I hereby certify that I attended the deceased from ____, 19____, to ____, 19____; that I last saw h____ alive on ____, 19____; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Apparent Coronary Occlusion	
Due to ____	
Due to Found dead in bed.	
Other conditions (Include pregnancy within 3 months of death) ____	
Major findings: Of operations ____	
Of autopsy No	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: No
(a) Accident, suicide, or homicide (specify) ____
(b) Date of occurrence ____
(c) Where did injury occur? No (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)
(e) Means of injury ____ While at work? No

23. Signature P. M. Hitts Justice of Peace (M. D. or other)
Address 111 Brown St. Liberty Mo Date signed 9/29/45
acting Coroner

142 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 10-10-XX

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.....

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.