DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 17236

FILED MAY 28 1947
Registration District No. 7 3 7

Primary Registration District No. 3023

Registrar's No. 121

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

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

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St Clair 9-7
(c) City or town Lowry City Mo
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Agnes Josephine Goad
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife None
6. (c) Age of husband or wife if alive years
7. Birth date of deceased December (Month) 27 (Day) 1865 (Year)
8. AGE: Years 81 Months 4 Days 21 If less than one day hr. min.
9. Birthplace Missouri (City, town, or county) (State or foreign country)
10. Usual occupation House keeper
11. Industry or business
FATHER 12. Name Ruben goad
13. Birthplace ohio (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Catherin Hufer
15. Birthplace Indiana (City, town, or county) (State or foreign country)
16. (a) Informant Russell E Barnard
(b) Address 3649 E 28 st Kansas City Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-19-1947 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Gem Mo
18. (a) Signature of funeral director C A Pickett
(b) Address Bronaugh Mo
19. (a) 5-19-47 (Date received local registrar) (b) R B Kenney (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18
year 1947 hour 2:35 AM minute M.
21. I hereby certify that I attended the deceased from May 14, 1947, to May 18, 1947; that I last saw her alive on May 16, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Shock	12 hr
Due to Fractured hip	18 hr
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Underline disease 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? (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)
While at work? (e) Means of injury

23. Signature J E Walker (M. D. or other)
Address Clinton Mo Date signed 5-19-47

(Licensed Embalmer's Statement on Reverse Side)

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 Tom Hurst

Licensed Embalmer No. 2782

P. O. Address Duquesne 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.

No. 2B
3-45
P I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

REC'D JUN 4 1947

State File No. ____

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 121

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:
(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 ____

2. USUAL RESIDENCE OF DECEASED:

(a) State ____ (b) County ____
(c) City or town ____ (If outside city or town limits, write "RURAL")
(d) Street No. ____ (If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME Agnes J. Good
3. (b) If veteran, name war ____ 3. (c) Social Security No. ____

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife ____ 6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased Dec (Month) 27 (Day) 1865 (Year)

8. AGE: Years 81 | Months 4 | Days ____ | If less than one day ____ hr. ____ min.

9. Birthplace ____ (City, town or county) Mo (State or foreign country)

10. Usual occupation ____

11. Industry or business ____

FATHER
12. Name ____
13. Birthplace ____ (City, town, or county) ____ (State or foreign country)

MOTHER
14. Maiden name ____
15. Birthplace ____ (City, town, or county) ____ (State or foreign country)

16. (a) Informant ____
(b) Address ____

17. (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (Month) (Day) (Year)
(c) Place: burial or cremation ____

18. (a) Signature of funeral director ____
(b) Address ____

19. (a) ____ (Date received local registrar) (b) ____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 19 year 1947 hour ____ minute ____ 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 ____	
Due to ____	
Due to ____	
Other conditions (Include pregnancy within 3 months of death) ____	
Major findings: Of operations ____	
Of autopsy ____	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident
(b) Date of occurrence May 17, 1947
(c) Where did injury occur? Tebeauville City (City or town) St Clair (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? home (Specify type of place)
While at work? yes (e) Means of injury Fractured

23. Signature J. Walker (M. D. or other) M.D.
Address Clinton Mo Date signed 6-9-47

SUPPLEMENTARY 19

17236