

FILED JUN 30 1947

Registration District No. 187

Primary Registration District No. 3088

Registrar's No. 49

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Brookfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: McDermey Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 36 hours
(Specify whether
in this community 80 years
years, months or days)

3. (a) PRINT FULL NAME KATHERINE GOOCH

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 2
6. (b) Name of husband or wife Wilber Gooch 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May-16-1860
(Month) (Day) (Year)

8. AGE: Years 87 Months 1 Days 0 If less than one day hr. _____ min. _____9. Birthplace Ontario, Canada
(City, town, or county) (State or foreign country)10. Usual occupation Housewife

11. Industry or business.

12. Name Isaac Adamson
13. Birthplace N.Y. Canada
(City, town, or county) (State or foreign country)
14. Maiden name Mary Ann Carter
15. Birthplace N.Y. Canada
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Roy Sturtevant
(b) Address Brookfield Mo.17. (a) Burial (b) Date thereof June-18-1947
(Burial, cremation, or removal) (Month) (Day) (Year)18. (a) Signature of funeral director Rose Hill Cemetery
(b) Address Brookfield Mo.19. (a) 6-18-47 (b) Walter Blum
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Linn 58
(c) City or town Brookfield
(If outside city or town limits, write "RURAL")
(d) Street No. 1126 N Main
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16
year 1947 hour 11 minute 30 a.m.21. I hereby certify that I attended the deceased from 5-20-47
to 6-16-47, 1947
that I last saw her alive on 6-16-47, 1947
and that death occurred on the date and hour stated above.Immediate cause of death Cerebral vascular accident

Duration

Due to Hypertensive crisis - cerebralDue to Generalized arteriosclerosisOther conditions Arteriosclerosis
(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) _____
(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? _____ Means of injury _____

23. Signature W. Blum (M. D. or other)
Address Brookfield Mo. Date signed 6/18/47

DISTRICT HEALTH OFFICE
Cameron, Mo.

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. *2246*

P. O. Address *Brookfield 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.