DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

35729 State File No.

Registration District No. 135 Primary Registration District No. 3010 Registrar's No. 126

1. PLACE OF DEATH:
(a) County Carroll
(b) City or town Carrollton (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
In this community Entire Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Carroll
(c) City or town Carrollton (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Mary Hudson Goodson
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Fe
5. Color or race W
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife J.B. Goodson
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb (Month) 2 (Day) 1853 (Year)

8. AGE: Years 86 Months 8 Days 23 If less than one day hr. min.
9. Birthplace Carroll Co. Mo. (City, town, or county) (State or foreign country)
10. Usual occupation At Home
11. Industry or business
FATHER 12. Name R.B. Hudson
13. Birthplace Virginia (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Cathrine O'Bear
15. Birthplace Virginia (City, town, or county) (State or foreign country)
16. (a) Informant's own signature Mrs. Robt. Brown
(b) Address Carrollton Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 27 1939 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Hill Cem
18. (a) Signature of funeral director Milton Standley
(b) Address Carrollton Mo.
19. (a) 10-27-39 (Date received local registrar) (b) Ruth Haskins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 25th
year 1939 hour 7 minute 30 A. M.
21. I hereby certify that I attended the deceased from Jan - 4th, 1939, to Oct 25th, 1939, that I last saw h alive on Oct 25th, 1939, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral apoplexy	
Due to Thrombosis	
Due to Cardiac degeneration & arteriosclerosis	
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)
(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.W. Cornelius (M. D. or other) D.O.
Address Carrollton Mo. Date signed 10-25-39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
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. 8,
District File Number
Date Filed 11/7/39

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 Ben W Gibson

Licensed Embalmer No. 296

P. O. Address Carrollton, M

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, above space should be left blank.