

No. 2  
4-2-43  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37951

State File No. \_\_\_\_\_

FILED DEC 13 1943

Registrar's No. 121

Registration District No. 33 Primary Registration District No. 3011

1. PLACE OF DEATH:

(a) County **Carroll**  
**Carrollton**

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

(c) Name of hospital or institution: **Staton Clinic**  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Lafayette 054**

(c) City or town **Waverly**  
(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 **Walter Goodwin**

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **16th**  
year **1943** hour **4** minute **45 P. M.**

4. Sex **Male** 5. Color or race **White**

6. (a) Name of husband or wife \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: **Sept. 18 1857**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **JUNE 11-1942**  
to **Nov 16 1943**  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

**86 1 28**

Immediate cause of death: **Chronic interstitial Nephritis**

9. Birthplace: **Concordia Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation: **Farmer**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: **Chronic Myocarditis**  
(Include pregnancy within 3 months of death)

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

12. Name: **James Goodwin**

13. Birthplace: **Va.**  
(City, town, or county) (State or foreign country)

14. Maiden name: **Martha Marshall**

15. Birthplace: **Sweet Springs, Mo.**  
(City, town, or county) (State or foreign country)

Major findings: **1/3/a**

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

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant: **Mrs. Byrdie L. Cooper**

(b) Address: **Waverly, Mo.**

17. (a) **Burial** (b) Date thereof: **Nov. 18, 1943**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **Waverly Cemetery**

18. (a) Signature of funeral director: **Willis-Marshall**

(b) Address: **Carrollton, Mo.**

19. (a) **11-18-43** (b) **Miss Jamesa Poffey**  
(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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature: **Geo. Jones** (M. D. or other) **NO**

Address: **Waverly, Mo.** Date signed: **11-18-43**

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

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District File Number

Date Filed

2-10-43

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 myself.

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed P. M. Marshall

Licensed Embalmer No. 25285

P. O. Address Carrollton 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.