

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County Garrison
Township Wear
City Kansas City (No. 1002)

Registration District No. 399
Primary Registration District No. 1002

File No. 35978
Registered No. 1400
St. 6 (Ward)

2. FULL NAME

William F. Golding
(a) Residence, No. 3945 Frost Ave St. 6 Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 13, 1899

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
83 7 14

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Shoemaker

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Franklin Missouri

13. NAME William F. Golding

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

15. MAIDEN NAME Frances E. Dennis

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT William F. Golding (ADDRESS) 8945 Frost

18. BURIAL, CREMATION, OR REMOVAL PLACE Harriet Hill DATE Nov. 29, 1932

19. UNDERTAKER Carroll Davidson Inc (ADDRESS) 3024 Frost Ave

20. FILED Nov 29, 1932 M. M. Laroux Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 27, 1932

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw him alive on 11-24, 1932 Death is said

to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage with partial paralysis
95B 95B 95B
Arteriosclerotic cardiovascular disease

Other contributory causes of importance:

Arteriosclerotic cardiovascular disease

Name of operation none Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____.

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) J. J. Bennett M. D.

(Address) 201 Central Hospital

WRITE PLAINLY WITH UNFADING INK--THIS IS 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.

MARGIN RESERVED FOR BINDING

U. S. NO. 2

