OCT 18 1939

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

31511
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson
Registration District No. 397
(b) Township
Primary Registration District No. 1002
Registered No. 3609
(c) or City Kansas City
(d) Street No. Trinity Lutheran Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 360 Chester Goodale
(a) Residence, No. 4429 Madison St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ----------
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 13, 1939
7. AGE: YEARS 0 MONTHS 0 DAYS 1½ If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none
9. Industry or business in which work was done, as 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) Kansas City Missouri

FATHER
13. NAME Robert C. Goodale
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jackson Co. Missouri

MOTHER
15. MAIDEN NAME Velma Marie Schupp
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jackson Co. Missouri

17. INFORMANT (ADDRESS) Robert C. Goodale 4429 Madison
18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Washington DATE Sept. 15, 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Gates Funeral Home K. C., Kansas
20. FILED 9-15, 1939 [signature] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 14, 1939
22. I HEREBY CERTIFY, That I attended deceased from Sept. 13, 1939, to Sept. 14, 1939
I last saw h..... alive on Sept. 14, 1939 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:

	Date of onset
Cerebral Hemorrhage	9-13-39
160 B	

Other contributory causes of importance:
Prematurity (8½ months)
Name of operation none Date of
What test confirmed diagnosis? Exam Was there an autopsy? yes

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? no
If so, specify
(Signed) Eugene H. Ferguson M. D.
(Address) 933 Prof. Bldg.

(Licensed Embalmer's Statement on Reverse Side)

MARGIN RESERVED FOR BINDING
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.
V. S. No. 2. 50M-9-19-38 I X16605

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.....

P. O. Address.....

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.