

CHEN FEB 26 1940  
Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
620 East Meyer Blvd.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution none  
(Specify whether  
In this community 48 years  
years, months or days)

8. (a) PRINT FULL NAME Mrs. Elizabeth Eustace Goodenow

8. (b) If veteran, name war No. 8. (c) Social Security No. No.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife Fred I. Goodenow 6. (c) Age of husband or wife if alive No years

7. Birth date of deceased October 26 1868  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>	<u>2</u>	<u>28</u>	hr. _____ min.

9. Birthplace Iowa  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business X

MOTHER FATHER  
12. Name Thomas Eustace  
13. Birthplace Illinois  
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Bowden  
15. Birthplace Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature A. M. Smith  
(b) Address 620 East Meyer Blvd., K. C., Mo.

17. (a) Burial (b) Date thereof 1-25-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director Stine & McClure  
(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) Jan. 24, 1940 (b) H. M. Ervine  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 620 East Meyer Blvd.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? No. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 23  
year 1940 hour 8:00 minute P M.

21. I hereby certify that I attended the deceased from 1939 to January 24, 1940; that I last saw her alive on January 24, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Bronchitis Cerebral Hemorrhage  
Duration 3 days

Due to Asteris-Sclerosis not known

Due to 131

Other conditions Typhoid & Cholera several years  
(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?

While at work? \_\_\_\_\_ (Specify type of play)  
(e) Means of injury 3

23. Signature Carl H. Smith (M.-D. or other) D.O.  
Address 201 Ruby Bldg. Date signed Jan 24/40

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.

1 X1031

Dr. Earl Smith

Wendy Taylor 7-2-80  
345th purchase - 7.

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

*Dewey Turner*

Registered Apprentice No. *122*

working under my personal supervision.

Signed

*[Signature]*

Licensed Embalmer No. *1415-*

P. O. Address *K.P. 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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

Do not use this space.

Registered No. **343**

1. PLACE OF DEATH

(a) County ..... Registration District No. ....  
 (b) Township ..... Primary Registration District No. ....  
 (c) City ..... (d) Street No. ....  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (If death occurred in Hospital or Institution, write its name instead of street and number)  
 How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. .... St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

*Elizabeth G. Bordenow*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **76** 4. COLOR OR RACE ..... 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) .....

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

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

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

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

FATHER 13. NAME .....  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) .....

MOTHER 15. MAIDEN NAME .....  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) .....

17. INFORMANT (ADDRESS) .....

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE .....

19. FUNERAL DIRECTOR (ADDRESS) .....

20. FILED **1/24** 19 **40** *M. M. Coove* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Jan 23 1940**

22. I HEREBY CERTIFY That I attended deceased from .....

I last saw h. alive on ..... 19..... 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:

*Indurated  
 lobes of both lungs  
 Acute Hemorrhage*

Date of onset **10/5**

Other contributory causes of importance:  
*Arteriosclerosis  
 Chronic Nephritic Cystitis*

Name of operation ..... Date of .....  
 What test confirmed diagnosis *Clinical* Was there an autopsy? .....

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) *Carl F. Smith, M.D.*  
 (Address) *201 Ruby Bldg.*

SUPPLEMENT

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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