DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 11 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 5310

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. F 535

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: St. Anthony's Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether years, months or days)

In this community all her life

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. 3224 Charlotte
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Marcia Goucher

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Fe

5. Color or race Wh

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept (Month) 21 (Day) 1939 (Year)

8. AGE: Years 0 Months 4 Days 13 If less than one day ..... hr. ..... min.

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

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name David Goucher
13. Birthplace Bethany (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Dorothy Vaughn
15. Birthplace North K. C. (City, town, or county) Mo (State or foreign country)

16. (a) Informant's own signature Mrs. David Goucher
(b) Address 3224 Charlotte

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-1940 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. St. Marys Cem.

18. (a) Signature of funeral director J. W. Wagner
(b) Address K. C. Mo

19. (a) Feb. 5, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 4th year 1940 hour 4 minute 30 P.M.

21. I hereby certify that I attended the deceased from Oct. 20 Oct. 20, 1939, to Feb. 4, 1940; that I last saw her alive on Oct. 4, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bilateral Primary Bronchial Pneumonia	36 hrs.
Due to	
Due to 10 Yrs	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy Bronchial Pneumonia	

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 Joseph Conrad (M. D. ~~or other~~)

Address 1308 Waldheim Bg Date signed Feb. 5 '40

(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.

I X19511

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 Cecil R Matthews

Licensed Embalmer No. 3807

P. O. Address K. C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.