

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1087

1. PLACE OF DEATH:

(a) County Jackson
Kansas City
(b) City or town
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 & 13 days
(Specify whether
In this community 40 Years
years, months or days)

3. (a) PRINT FULL NAME FRANCES MARY GOOCH 2A0

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 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 January 24 1862
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>77</u>	<u>1</u>	<u>14</u>	hr. _____ min. _____

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name Charles Gooch

18. Birthplace Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Hellegus Sabiar

15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Martha Jenkins

(b) Address 3311 Holmes Street

17. (a) Burial (b) Date thereof Mar. 10, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Urich, Missouri

18. (a) Signature of funeral director D. H. Newcomer's Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) Mch 9 1940 (b) M. M. Crow
(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. 4822 Charlotte
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 10 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 7th
year 1940 hour 4 minute 11 A.M.

21. I hereby certify that I attended the deceased from
1-23-40, 19____, to 3-7-40, 19____;

that I last saw h alive on 3-7-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of humerus and femur, accidental fall in home

Due to _____
Due to _____

Other conditions Diabetes
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Acc

(b) Date of occurrence Jan 23 1940

(c) Where did injury occur? at home (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 Fall

23. Signature Dr. De Maria M.D. (M. D. or other)
Supt. A.C. Gen. Hospital, K.C. Mo. Date signed _____
Address _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

NO. 2-17-30 I X1931

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.

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 Carole M. Ashworth

Licensed Embalmer No. 3506

P. O. Address K. C. 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.