

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

20942

State File No.

2559

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

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: Research Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Day (Specify whether
In this community 35 years (Specify whether
years, months or days)

3. (a) PRINT FULL NAME GEORGE D. GOETZ

3. (b) If veteran, name war No 3. (c) Social Security No. 486-05-0855

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Mrs. Bella Goetz 6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased Dec. 24 1890
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>49</u>	<u>5</u>	<u>28</u>	hr. min.

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

10. Usual occupation Baker

11. Industry or business Baking

12. Name John Goetz

13. Birthplace Germany (City, town, or county) (State or foreign country)

14. Maiden name Katherine Herster

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

16. (a) Informant's own signature Mrs. Bella Goetz

(b) Address 2311 E. 49th St. K.C. Mo.

17. (a) Calvary Cem. (b) Date thereof 6/25/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Hillham Plaza, K.C. Mo.

19. (a) JUNE 24, 1940 (b) M. M. Renow
(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. 2311 E. 49th Street
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 23
year 40 hour 5 minute P M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Contusion of the scalp;
Fracture of the skull;
Blow by blunt force

Due to _____

Other conditions (include pregnancy within 3 months of death) 145 lbs

Major findings: _____

Of operations _____

Of autopsy See above

Duration

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) Schmitten

(b) Date of occurrence 6/21/40

(c) Where did injury occur? Kansas City, Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Solom

While at work? Yes (Specify type of place) (e) Means of injury _____

3. Signature Chas. J. Fitch (M. D. or D. O.)

Address Keew Date signed 6/24/40

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 X1811

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

J B Waters

Licensed Embalmer No.

3992

P. O. Address

K E Mc

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.