

No. 1  
1-1-39  
-17-39  
X21492

NOV 12 1940  
DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

34421

State File No.

3937

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Kansas City, Mo.  
 (c) Name of hospital or institution: 137 S White  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 70 years  
 In this community 70 years  
 (Specify whether years, months or days)

8. (a) PRINT FULL NAME George G. Goodwin  
 (b) If veteran, name war None  
 3. (c) Social Security No. None

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Mabel Goodwin 6. (c) Age of husband or wife if alive Unobtainable years  
 7. Birth date of deceased Jan. 22, 1879  
 (Month) (Day) (Year)

8. AGE: Years 70 Months 8 Days 19 If less than one day hr. min.

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

10. Usual occupation Retired Realstate & Insurance

11. Industry or business S  
 MOTHER FATHER { 12. Name William Goodwin  
 18. Birthplace N.Y.  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Anna Rouch  
 15. Birthplace \_\_\_\_\_  
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mabel Goodwin  
 (b) Address 137 S White, K.C. Mo.

17. (a) Burial (b) Date thereof Oct. 11-40  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Marys Cemetery

18. (a) Signature of funeral director C.H. Blackman & Son, Inc.  
 (b) Address 13

19. (a) 10-14-40 (b) M. M. Brown  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
 (c) City or town Kansas City, Mo.  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 137 S. White  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 11th.  
 year 1940 hour 4 minute 40 P. M.

21. I hereby certify that I attended the deceased from Jan. 18  
1939, to Oct. 11, 1940  
 that I last saw him alive on Oct. 11, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death 3d attack of Partial Cerebral Hemorrhage  
 Due to Arterio Sclerosis of Aorta 2 years  
 Due to High blood pressure.

Other conditions \_\_\_\_\_  
 (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?

(Specify type of place) \_\_\_\_\_  
 While at work? \_\_\_\_\_ (b) Means of injury !

23. Signature E. H. Ziehlinger (M. D. or other)  
 Address 715 Riggle Bldg. Date signed 10/12-40

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

Dr. Ziellinger,

Argyle Bldg.

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**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 W.D. Blackman

Licensed Embalmer No. 3639

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.**

No. 2  
-1-4-41  
5-17-39

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

# MISSOURI STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH

State File No. 34421

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3937

### 1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town K.C.  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution.....  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Geo. G. Goodwin

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

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

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

7. Birth date of deceased:  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>8</u>	<u>19</u>	hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER  
 { 12. Name  
 { 13. Birthplace (City, town, or county) (State or foreign country)  
 { 14. Maiden name  
 { 15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant.....  
 (b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)  
 (c) Place: burial or cremation.....

18. (a) Signature of funeral director.....  
 (b) Address.....

19. (a) 10/13/41 (Date received local registrar)  
 (b) M. M. Brown (Registrar's signature)

### 2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
 (c) City or town.....  
(If outside city or town limits, write "RURAL")  
 (d) Street No.....  
(If rural, give location)  
 (e) Citizen of foreign country?..... (Yes or No)  
 If yes, name country.....

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 11  
 year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to.....  
 that I last saw h..... alive on..... and that death occurred on the date and hour stated above.  
 Immediate cause of death.....

Duration

Other conditions.....  
(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 place)  
 (e) Means of injury.....

23. Signature E. H. Zeilinger (M. D. or other)  
 Address 715-Argyle Bldg Date signed.....

(Licensed Embalmer's Statement on Reverse Side)

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

SUPPLEMENTARY

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**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, fact should be so stated above.**