

S. No. 2  
-1-4-41  
5-17-39  
P-I X26390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 30530  
3287  
Registrar's No. \_\_\_\_\_

Sub. District No. 103-99

Primary Registration District No. 1002

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

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: General Hospital #2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 8-18-41-8-28-41  
(Specify whether years, months or days) 22 years

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. 3637 Bellaire  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME DELLA GOODWIN  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month August day 28th  
year 1941 hour 8 minute 45 a.m.  
21. I hereby certify that I attended the deceased from 8-18-41 1941 to 8-28-41 1941  
that I last saw him alive on August 28 1941  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married  
(b) Name of husband or wife Scott Goodwin (c) Age of husband or wife if alive 60 years  
7. Birth date of deceased October 1 1895  
(Month) (Day) (Year)

Immediate cause of death  
Lung abscesses (bilateral)  
right sided empyema Non tuberculous  
Due to \_\_\_\_\_  
Terminal confluent broncho-pneumonia  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) None

8. AGE: Years Months Days If less than one day  
45 10 27 hr. min.  
9. Birthplace Houston Miss. 1  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

10. Usual occupation Unemployed  
11. Industry or business \_\_\_\_\_  
12. Name Sam May  
13. Birthplace Houston Miss. 1  
(City, town, or county) (State or foreign country)

14. Maiden name Mattie Hopson  
15. Birthplace Houston Miss. 1  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant Scott Goodwin, husband  
(b) Address 3637 Bellaire  
17. (a) Burial (b) Date thereof 9 2 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Lincoln  
18. (a) Signature of funeral director Adkins Bros.  
(b) Address 912 P.O.E. 12th K.C. Mo.  
19. (a) 9/2/41 (b) H. M. Cronin  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) Means of injury \_\_\_\_\_  
23. Signature [Signature] (a) D. or other? [Signature]  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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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.....

*Edu J. Evans*

Licensed Embalmer No..... *3836*

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.**