

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26389
State File No. _____
3302
Registrar's No. _____

FILED SEP 11 1942
Registration District No. _____

Primary Registration District No. 1002

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

1. PLACE OF DEATH:
 Jackson
 (a) County...
 (b) City or town... Kansas City
 (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... 8 days
 (Specify whether years, months or days)
 In this community... 30 years

2. USUAL RESIDENCE OF DECEASED:
 Missouri Jackson 48
 (a) State... (b) County...
 (c) City or town... Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No... 2450 Charlotte St
 (If rural, give location)
 (e) Citizen of foreign country?... (Yes or No)
 If yes, name country...

3. (a) PRINT FULL NAME... Lydia Goldsberry
 3. (b) If veteran, name war... No
 3. (c) Social Security No... None

4. Sex... Female
 5. Color or race... White
 6. (a) Single, widowed, married, divorced... Widowed
 6. (b) Name of husband or wife... unknown
 6. (c) Age of husband or wife if alive... years
 7. Birth date of deceased... August 22 1874
 (Month) (Day) (Year)

8. AGE:
 Years: 68
 Months: 0
 Days: 12
 If less than one day: hr. min.

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

10. Usual occupation... Housewife

11. Industry or business...

MOTHER FATHER
 12. Name... J. P. Strickland
 13. Birthplace... Missouri
 (City, town, or county) (State or foreign country)
 14. Maiden name... Christine Groff
 15. Birthplace... Ohio
 (City, town, or county) (State or foreign country)

16. (a) Informant... Mrs. H. L. Walters
 (b) Address... 339 South Kensington

17. (a) Removal... (Burial, cremation, or removal)
 (b) Date thereof... Sept. 5, 1942
 (Month) (Day) (Year)
 (c) Place: burial or cremation... Centerville, Iowa

18. (a) Signature of funeral director... Quirk & Tobin
 (b) Address... 2934 Linwood

19. (a) Date received local registrar... 9/5/42
 (b) M. M. Crowe
 (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month... Sept. day... 4th
 year... 1942 hour... 11 minute... 25 A.M.
 21. I hereby certify that I attended the deceased from... 8-27-42
 to... 9-4-42
 that I last saw her alive on... 9-4-42
 and that death occurred on the date and hour stated above.

Immediate cause of death... Intestinal obstruction
 Due to... Incarcerated femoral hernia
 Due to...
 Other conditions...
 (Include pregnancy within 3 months of death)
 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)...
 (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... Means of injury...
 23. Signature... M. D. or other...
 Address... Med. Dir. K.C. Gen. Hospital Date signed...

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 *Jack W. Laybourne*
Licensed Embalmer No. *1715*

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.