

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1308

1. PLACE OF DEATH:  
 (a) County. Jacks on  
 (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 No. 2  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution. 3-12-43- 9 hr.  
 (Specify whether  
 In this community. 6 months  
 years, months or days)

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. 1315 Olive  
 (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country. no

3. (a) PRINT FULL NAME BEULAH MAE GOODWIN  
 3. (b) If veteran, no name war. no  
 3. (c) Social Security No. none

4. Sex. Female 3 Color or 3 race. Negro  
 5. (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. April 25 1927  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
15 10 19 hr. min.

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

10. Usual occupation. Bus-girl

11. Industry or business. Business

12. Name. Bert Goodwin

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

14. Maiden name. Vera Visor

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

16. (a) Informant. Record Clerk

(b) Address. General Hospital No. 2

17. (a) Removed (b) Date thereof. 3-16-43  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Wenaustruburg

18. (a) Signature of funeral director. Edwin Greenstreet

(b) Address. 1819 E. 15th

19. (a) 3/16/43 (b) M. M. Crowe  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 12  
 year 1943 hour 1:15 minute 0 P. M.

21. I hereby certify that I attended the deceased from March 12, 1943  
3:25 a.m. to 1:15 p.m.  
 that I last saw her alive on March 12, 1943  
 and that death occurred on the date and hour stated above.

Immediate cause of death. Acute Congestive Heart Failure

Due to Tumor of adrenal medulla with hypertension. Non Malignant

Due to 56E

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy. Same as above

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 J. H. Hagedorn (M. D. or other)

Address Law, Hagedorn 2-60822 Date signed 3-16-43

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

MOTHER FATHER

361

(Licensed Embalmer's Statement on Reverse Side)

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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. *2211*

P. O. Address. *1819 E. 10th*

**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.**