

Registration District No. FILED JAN 5 1969

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: TRINITY LUTHERAN HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 DAYS
(Specify whether years, months or days)

In this community 40 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON ⁴⁸

(c) City or town KANSAS CITY
(If outside city or town limits, write "RURAL")

(d) Street No. 1609 WEST 39TH STREET
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME MR DAVIS GODDARD

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE

6. (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 OCTOBER 1 1861
(Month) (Day) (Year)

8. AGE: Years 82 Months 2 Days 19
If less than one day hr. min.

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

10. Usual occupation DRUGGIST

11. Industry or business RETIRED

12. Name JOHN GODDARD

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

14. Maiden name ANN KING

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

16. (a) Informant MRS. FRANKIE COULTER

(b) Address 1609 WEST 39TH STREET

17. (a) BURIAL (b) Date thereof DEC 21 19
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT. MORIAH CEM.

18. (a) Signature of funeral director D. H. Newcomer, Jr.

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 12-21-63 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 20
year 43 hour 4 minute 10 A.M.

21. I hereby certify that I attended the deceased from 12-18
43, 1943, to 12-20-43;
that I last saw h. in alive on 12-20-43, 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death Left Lobar Pneumonia
2. Right Broncho pneumonia
3. Probable Hypertrophy
Due to 4. Chronic cystitis

Due to 1376

Other conditions ---
(Include pregnancy within 3 months of death)

Major findings: Of operations ---

Of autopsy 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)
(c) Means of injury ---

23. Signature Gerald B. Peers, MD (M.D. or other)
Address Trinity Hospital Date signed 12-20-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Emile M. Calhoun

Licensed Embalmer No. 3506

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, fact should be so stated above.