

FILED JAN 5 1944 149
Registration District No. 1944/149

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 No. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12-14-43-12-15-43
(Specify whether years, months or days)

In this community 50 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME NOAH GOFF

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male 5. Color or race Negro

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Katie Goff

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased April 15 1863
(Month) (Day) (Year)

8. AGE: Years 80 Months 8 Days 10 If less than one day 0
hr. min.

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

10. Usual occupation Unemployed

11. Industry or business

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Record Clerk

(b) Address General Hospital No. 2

17. (a) Burial (b) Date thereof 12-21-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland

18. (a) Signature of funeral director Adkins Bros.

(b) Address 6000 E. 13th

19. (a) 12-21-43 (b) N. E. 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
(If outside city or town limits, write "RURAL")

(d) Street No. 2454 Euclid
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 15
year 1943 hour 12:50 minute P. M.

21. I hereby certify that I attended the deceased from December 14, 1943, to December 15, 1943
that I last saw him alive on December 15, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia

Due to Aortic Stenosis

Due to 92a

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy Same as 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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature G. O. Brown (M. D. or other) _____
Address Gen Hospital 2 6006 22nd Date signed 12/16/43

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.