

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 27 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11161

State File No. _____

Registration District No. 150

Primary Registration District No. 5572

Registrar's No. 21

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Rural Prairie, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Jackson County Home for Aged
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 mo.
(Specify whether _____)

In this community _____
years, months or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

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

(d) Street No. 1229 Washington
(If rural, give location)

(e) Citizen of foreign country? no. (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Chas. A. Goodwin

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M 5. Color or race W 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 Nov. 4 1889
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
54 3 24 hr. _____ min.

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

10. Usual occupation none

11. Industry or business _____

12. Name unknown

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

14. Maiden name _____

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

16. (a) Informant Reverend Jackson County Home

(b) Address Rt. 4, Independence, Mo.

17. (a) Burial (b) Date thereof 2-28-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Leo's Summit

18. (a) Signature of funeral director M. B. Longford

(b) Address Leo's Summit, Mo.

19. (a) Feb 24, 1944 (b) F. M. Schick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 26
year 1944 hour 11:15 minute 9 M.

21. I hereby certify that I attended the deceased from 5/12, 1943, to 2/26, 1944
that I last saw him alive on 2/25 and that death occurred on the date and hour stated above.

Immediate cause of death: mitral regurgitation

Due to _____

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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. W. Brewer (M. D. or other) _____
Address Independence Mo Date signed 2/27/44

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

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

W. B. Langford

Licensed Embalmer No.

3833

P. O. Address

2100 Summit

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.