

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 5 1947

State File No. _____

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 1843

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: Menorah Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 28 days
(Specify whether years, months or days)

In this community 35 years

3. (a) PRINT FULL NAME Mrs. Grace Goodale

3. (b) If veteran, name war no.

3. (c) Social Security No. no.

4. Sex female

5. Color or race white

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

6. (b) Name of husband or wife: x unknown

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

7. Birth date of deceased: October 30 1871
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
75	5	22	hr. min.

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

10. Usual occupation at home

11. Industry or business x

MOTHER FATHER {

12. Name C. E. Goodale

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

14. Maiden name unknown

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

16. (a) Informant J. R. Goodale

(b) Address 1015 E. Armour, Kansas City, Mo.

17. (a) removal (Burial, cremation, or removal) (b) Date thereof: 4-28-47
(Month) (Day) (Year)

(c) Place: burial or cremation Rushville, Illinois

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 4-23-47 (Date received local registrar) (b) Geraldine Holmes (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. 1015 East Armour Blvd.
(If rural, give location)

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

If yes, name country x

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22
year 1947 hour 5:20 minute A. M.

21. I hereby certify that I attended the deceased from Jan 1 1945 to Apr 22 1947
that I last saw him alive on April 21 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Acute coronary occlusion 2 days

Due to: _____

Due to: generalized arteriosclerosis 2 yrs

Other conditions (Include past ones within 3 months of death): and hypertension

Major findings: _____

Of operations: _____

Of autopsy: gya

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) Means of injury: _____

23. Signature: Almona Hubert (M. D. or other)

Address: 420 Prof. Date signed: 4-22-47

Dr. Ginsberg

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. 1425

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.