

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:
3237 McGee /
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)
 In this community 74 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson **48**
 (c) City or town Kansas City **3**
(If outside city or town limits, write "RURAL")
 (d) Street No. 3237 McGee **8**
(If rural, give location)
 (e) Citizen of foreign country? No **0**
(Yes or No)
 If yes, name country _____ **X**

3. (a) PRINT FULL NAME MINNIE E. GOUNOD

(b) If veteran, name war NO (c) Social Security No. NONE

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow **2**
 (b) Name of husband or wife C. E. Gounod - (deceased) 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased February 17 1872
(Month) (Day) (Year)

8. AGE: Years 75 Months 7 Days 12 If less than one day hr. _____ min. **0**

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

10. Usual occupation Home

11. Industry or business X

MOTHER FATHER { 12. Name Joseph W. Kimble **1**
 13. Birthplace Ohio
(City, town, or county) (State or foreign country)
 14. Maiden name Sarah Ann Reed
 15. Birthplace Missouri **0**
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Aurora Champe
 (b) Address 3237 McGee K. C. Mo

17. (a) Removal (b) Date thereof Oct 1, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn Cemetery K. C. Ks.

18. (a) Signature of funeral director Wilks Funeral Home

(b) Address 2315 Linwood K. C. 3 Mo

19. (a) 9-30-47 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 29
 year 1947 hour 11 minute 25 AM.

21. I hereby certify that I attended the deceased from September 1946 to September 29 1947
 that I last saw her alive on 9-26 and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory paralysis
 Duration 6 hours

Due to Cardiac decompensation and Myocarditis

Due to Asperger's disease

Other conditions Cerebral arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
 Of autopsy _____
938

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? C. Ks. **1)**

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

23. Signature Wm. J. [unclear] (M. D. or other) **Dr**
 Address 3034 [unclear] Date signed 9-30-47

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

Dr. Jasper

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..... *Chas E. Wilks*

Licensed Embalmer No. *2644*

P. O. Address. *Kansas City 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.