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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 12584

FILED MAY 15 1948

Registration District No. 949

Primary Registration District No. 1002

Registrar's No. 1894

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St. Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 hours (Specify whether
In this community 12 hrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Ray
(c) City or town Orrick
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

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3. (a) PRINT FULL NAME Susan Carrol Gooch
3. (b) If veteran, name war no
3. (c) Social Security No. none.

4. Sex female
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 May (Month) 1 (Day) 1948 (Year)

8. AGE: Years | Months | Days | If less than one day 12 hr. min.

9. Birthplace Kansas City (City, town, or county) Missouri (State or foreign country)
10. Usual occupation infant
11. Industry or business
FATHER
12. Name Clifford Gooch
13. Birthplace Orrick (City, town, or county) Missouri (State or foreign country)
MOTHER
14. Maiden name Virginia Thomas
15. Birthplace Cower (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Virginia Gooch
(b) Address Orrick Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/2/48 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Orrick Missouri
18. (a) Signature of funeral director B. W. Good
(b) Address Orrick, Missouri
19. (a) 5-2-48 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2 year 1948 hour 5 minute 10 A M.

21. I hereby certify that I attended the deceased from ..... 19..., to ..... 19...; that I last saw her alive ..... 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Premature Infant
Due to Bilateral Atelectasis
Due to Premature Labor
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations 15
Of autopsy above

Duration

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Russell Kennel (M.D. or other)
Address St Joseph Hospital Date signed 2 May 48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 Not Embalmed 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.