

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

491

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No.			
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson					
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. LENGTH OF STAY (In this place) 72 Yrs		c. CITY OR TOWN Kansas City		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION 3238 Karnes Blvd				STREET ADDRESS (If rural, give location) 4400 3238 Karnes Blvd					
3. NAME OF DECEASED (Type or Print) Arthur			a. (First)	b. (Middle) A	c. (Last) Goulding	4. DATE OF DEATH (Month) (Day) (Year) Feb 1 1955			
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married		8. DATE OF BIRTH Nov 4, 1882		9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours	IF UNDER 15 MINS. Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Owner		10b. KIND OF BUSINESS OR INDUSTRY Tavern		11. BIRTHPLACE (City and State or Foreign Country) Kansas City, Kans			12. CITIZEN OF WHAT COUNTRY? U.S.A		
13a. FATHER'S NAME Patrick Goulding			13b. MOTHER'S MAIDEN NAME Sara Groves			14. NAME OF HUSBAND OR WIFE ----			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT'S SIGNATURE OR NAME MR. JOHN GOULDING, K.C., KAN.				ADDRESS 1701 LAKE ST.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH 4200		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.									
23a. SIGNATURE Geo. C. Kealhofer (Degree or title) Geo. C. Kealhofer, M.D., Surgeon				23b. ADDRESS 6627 Ward St. Kansas		23c. DATE SIGNED 2-2-55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 2-4-55	24c. NAME OF CEMETERY OR CREMATORY St. Joseph Cemetery		24d. LOCATION (City, town, or county) (State) Shawnee, Kansas				
DATE REC'D BY LOCAL REG. 2-3-55		REGISTRAR'S SIGNATURE Neva Marshall			25. FUNERAL DIRECTOR'S SIGNATURE Gates Funeral Home-Kansas City, Kan.			ADDRESS	

(Licensed Embalmer's Statement on Reverse Side)

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

FILED FEB 24 1955

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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *H. Forrest D. Caldwell*

Licensed Embalmer No. *4714*

P. O. Address *K.C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.