

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

32789

**1. PLACE OF DEATH**

County Jackson  
Township Kaw  
City Kansas City (No. 3220 paseo)

Registration District No. 399  
Primary Registration District No. 1002

File No. \_\_\_\_\_  
Registered No. 4007 Ward \_\_\_\_\_

**2. FULL NAME**

William D. Godkin

(a) Residence. No. 3220 Paseo St. 13 Ward.

(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male  
4. COLOR OR RACE White  
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Anna Godkin

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 4, 1838

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	92	2	28	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Retired  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Canada

10. NAME OF FATHER William G. Godkin

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Ireland

12. MAIDEN NAME OF MOTHER Maria Godkin

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Ireland

14. INFORMANT Grace Godkin (Address) 3220 Paseo

15. FILED 10/2/30 M. M. Grove REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) October 2, 1930

17. I HEREBY CERTIFY, That I attended deceased from July 25<sup>th</sup> 1930 to Oct 2<sup>nd</sup> 1930 that I last saw him alive on Oct 2<sup>nd</sup> 1930 and that death occurred, on the date stated above, at 9:45 A. M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Acute Broncho Pneumonia  
in H. D.  
1074 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) Carcinoma of Rectum (duration) 1 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_  
DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Laboratory & Clinical  
(Signed) Samuel Davis M. D.

10-2-1930 (Address) 814 Maple Bldg.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

Forest Hill Cem. 10-2-1930

20. UNDERTAKER Stone & McClure ADDRESS 3285

Gillham Plaza

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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