

Registration District No. 399

Primary Registration District No. 1002

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:  
K.C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 days  
(Specify whether same years, months or days)

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. 4612 E. 9th  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME GOODWIN INFANT 350

3. (b) If veteran, name war \_\_\_\_\_ No. \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced S.

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased April 7th 1940  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
			<u>4</u>	hr. _____ min. _____

9. Birthplace K.C. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business \_\_\_\_\_

12. Name William Goodwin

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

14. Maiden name Beulah Hoffman

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

16. (a) Informant's own signature Record clerk

(b) Address K.C. Gen. Hosp.

17. (a) Burial (b) Date thereof 4-23-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Municipal Cem.

18. (a) Signature of funeral director Leds. Co. W.A. Lohmeyer

(b) Address Gen. Hosp. No. 1

19. (a) 4-22-1940 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 11th  
 year 1940 hour 9:00 minute A. M.

21. I hereby certify that I attended the deceased from April 7th 1940 to April 11th 1940;  
 that I last saw her alive on April 11th, 1940, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity  
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Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions See above  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
See above

Duration \_\_\_\_\_  
 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) (e) Means of injury \_\_\_\_\_

23. Signature P. DeManna M.D. (M. D. or other) \_\_\_\_\_  
 Supt. K.C. General Hospital, K.C. Mo.  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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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**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.....

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, above space should be left blank.**