

No. 2
5-43
5-17-39
I X36671

Registration District No. 149

Primary Registration District No. 1002

State File No. _____

Registrar's No. 4102

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: TRINITY-LUTHERAN HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 weeks
Specify whether
In this community 2 weeks
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 48
(c) City or town GRANDVIEW
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME LINCOLN H. GODDARD

3. (b) If veteran, name war no 3. (c) Social Security No. 495-05-9083

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M-I
6. (b) Name of husband or wife ADAM B. GODDARD 6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased OCT. 31 1889
(Month) (Day) (Year)

8. AGE: Years 56 Months 10 Days 25 If less than one day hr. min.

9. Birthplace DOW CITY IOWA I
(City, town, or county) (State or foreign country)

10. Usual occupation CONTRACTOR

11. Industry or business CARPENTERING

12. Name ALBERT V. GODDARD

13. Birthplace PA. I
(City, town, or county) (State or foreign country)

14. Maiden name AGNES JEAN KULE

15. Birthplace IOWA I
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. L. H. GODDARD

(b) Address GRANDVIEW, MO.

17. (a) BURIAL (b) Date thereof Sept 29 '46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FLORAL HILLS, K.S. Mo.

18. (a) Signature of funeral director E. R. George
(b) Address Floral Hills, Mo.

19. (a) 9-28-46 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 26 day 26
year 1946 hour 8 minute 55 A.M.

21. I hereby certify that I attended the deceased from July
1946 to Death 19____;
that I last saw him alive on 26 Sept '46 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Circulatory collapse Duration _____

Due to long illness - Ca. of descending colon

Other conditions Incontinence 462
(Include pregnancy within 3 months of death)

Major findings: Of operations Ca. descend. colon

Of autopsy _____

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 0

23. Signature Robert M. Meyer (M. D. or other) M.D.
Address 1025 North 13th Date signed 26 Sept

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

29050

46

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..... *A. H. George*

Licensed Embalmer No..... *3645*

P. O. Address..... *Grandview 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.