

No. 2
-12-45
-17-39
X47070

FILED DEC 9 1946
Registration District No. **149**

Primary Registration District No. **1002**

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

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:
GENERAL HOSPITAL NO. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **11 DAYS**
(Specify whether in this community **37 YRS.** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **JACKSON 48**

(c) City or town **KANSAS CITY**
(If outside city or town limits, write "RURAL")

(d) Street No. **3637 BELLAIRE**
(If rural, give location)

(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **SCOTT GOODWIN**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **495-05-4681**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **NOVEMBER** day **24**, year **1946** hour **3**: minute **25 P.** M.

4. Sex **MALE 2** 5. Color or race **NEGRO**

6. (a) Single, widowed, married, divorced **divorced**

6. (b) Name of husband or wife **unknown**

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **DECEMBER 25, 1879**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **NOVEMBER 13, 1946** to **NOVEMBER 24, 1946**
that I last saw h. **IM** alive on **NOVEMBER 24, 1946**
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
66	10	29	_____ hr. _____ min.

Immediate cause of death **CEREBRAL VASCULAR ACCIDENT** Duration _____

Due to **HYPERTENSIVE HEART DISEASE**

Due to _____

9. Birthplace **CHARLESTON SOUTH CAROLINA**
(City, town, or county) (State or foreign country)

10. Usual occupation **Hod-carrier**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **and**

Of operations _____

Of autopsy _____

11. Industry or business

MOTHER FATHER {

12. Name **GRACUS GOODWIN 9**

13. Birthplace **Unknown 1**
(City, town, or county) (State or foreign country)

14. Maiden name **CHARITY SMITH 9**

15. Birthplace **Unknown 9**
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant **ANNIE BELLOWES (FRIEND)**

(b) Address **2500 CHESTNUT**

17. (a) **Burial** (b) Date thereof **11/30/46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lincoln Cemetery**

18. (a) Signature of funeral director **Wethers Bros.**

(b) Address **1729 Lyda Ave.**

19. (a) **11-27-46** (b) **E. M. Holmes**
(Date received local registrar) (Registrar's signature)

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 **11**

23. Signature **[Signature]** M. D. or other **M.D.**

Address **GENERAL HOSPITAL NO. 2** Date signed **11/25/46**

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.....

.....
working under my personal supervision.

..... Registered Apprentice No.....

Signed.....

J. Jerome Manlove

..... Licensed Embalmer No. *3994*

..... P. O. Address *2503 Highland*

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.