

7. S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36871

FILED MAR 21 1947

State File No. \_\_\_\_\_

Registration District No. 147

Primary Registration District No. 1002

Registrar's No. 999

1. PLACE OF DEATH

(a) County Jackson

(b) City or town Jackson City  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1323 Bales  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community 20 yrs  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson <sup>48</sup>

(c) City or town Kansas City <sup>3</sup>  
(If outside city or town limits, write "RURAL")

(d) Street No. 1323 Bales <sup>8</sup>  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) <sup>0</sup>

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Robert J. Goodwin

3. (b) If veteran, name war World War #1

3. (c) Social Security No. 573-18-8600

4. Sex Male

5. Color of race white

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

6. (b) Name of husband or wife Rena C Goodwin

6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased: Sept-17-1886  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month mar day 4 year 1947 hour 2 minute 30 a.m.

21. I hereby certify that I attended the deceased from March 3 1947 to March 4 1947

that I last saw him alive on March 3 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis

8. AGE:	Years	Months	Days	If less than one day
	<u>60</u>	<u>5</u>	<u>17</u>	hr. _____ min. _____

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Angina Pectoris & Mitral Regurgitation

(Include pregnancy & time in months of death)

Major findings: 928

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

10. Usual occupation Asst. Night Super.

11. Industry or business Kline Store Co

12. Name Goodwin

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

14. Maiden name No Record

15. Birthplace No Record  
(City, town, or county) (State or foreign country)

16. (a) Informant Rena C Goodwin

(b) Address 1323 Bales

17. (a) Burial (b) Date thereof Mar-6-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hill Cem.

18. (a) Signature of funeral director Miss C. R. Foster

(b) Address 914 Brooklyn

19. (a) 3-5-47 (b) Geraldine 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 \_\_\_\_\_

23. Signature Shirley Dugay (M. D. or other) <sup>0</sup>

Address 1401 Prospect Date signed 3-4-47

Duration of illness \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

10m

**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.....

*Jerry A. Minor*, Registered Apprentice No. *437*  
working under my personal supervision.

Signed *Corland Minor*

Licensed Embalmer No. *3414*

P. O. Address *918 Broadway*  
*R. C. Minor*

**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.**