

Registration District No. \_\_\_\_\_

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 **Home - 1605 Cypress Ave.**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 Month**  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson** **48**

(c) City or town **Kansas City** **3**  
(If outside city or town limits, write "RURAL")

(d) Street No. **1605 Cypress Ave.** **8**  
(If rural, give location) **0**

(e) Citizen of foreign country? **No** (Yes or No)

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

3. (a) PRINT FULL NAME **Anna S. Goolsby**

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

3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**

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

6. (b) Name of husband or wife **William W. Goolsby** 6. (c) Age of husband or wife if alive **77** years

7. Birth date of deceased **July 28th, 1878**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

**69** **5** **18** hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business **Home**

12. Name **Henry Wolff**

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

14. Maiden name **Unknown**

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

16. (a) Informant **William Tyson**

(b) Address **1605 Cypress Ave.**

17. (a) **Removal** (b) Date thereof **1/17/48**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Falls City, Neb.**

18. (a) Signature of funeral director **Earp & Sons**

(b) Address **4139 East 15th, St.**

19. (a) **1-16-48** (b) **E. Geraldine Holmes**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **16th**, year **1948** hour **8** minute **A.** M.

21. I hereby certify that I attended the deceased from **Jan 1, 48**, 19\_\_\_\_, to **Jan 16**, 19\_\_\_\_, that I last saw **her** alive on **Jan 16**, 19\_\_\_\_, and that death occurred on the date and hour stated above. **48** **48**

Immediate cause of death **Cerebral Myocarditis** **2 Days**

Due to **Myocardial Reg** **2 yr**

Due to **Arteriosclerosis** **4 yr**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **90%**

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 **P. L. St. Clair** (M. D. or other)

Address **5242 St. John** Date signed **1/16-48**

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

MOTHER FATHER

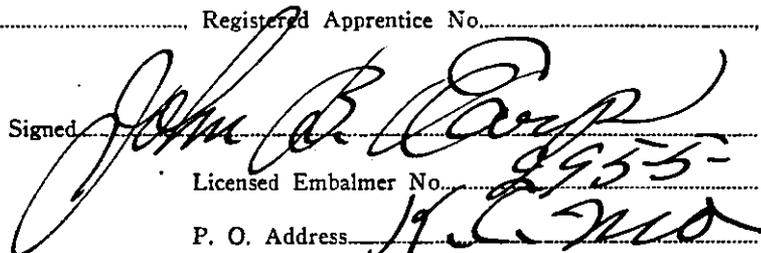
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STATEMENT BY LICENSED EMBALMER

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, fact should be so stated above.