CITY OF NEW YORK — BUREAU OF VITAL RECORDS — APR 28 1983

A 1024 -1931

Form 15 H 25-2609-31-B

STATE OF NEW YORK
Department of Health of The City of New York
BUREAU OF RECORDS
STANDARD CERTIFICATE OF DEATH

Register No. 21428

1 PLACE OF DEATH
BOROUGH OF Manhattan
Name of Institution V.P. Knickerbocker Hospital

FULL NAME Edward Goodchild

SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word)
Male	White	Single

DATE OF BIRTH
..... (Month) ..... (Day) ....., 1 (Year)

AGE
10 yrs. ..... mos. ..... ds.
If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
a) Trade, profession or particular kind of work: School
(b) General nature of industry, business or establishment in which employed (or employer): .....
c) No. of years so occupied: .....

BIRTHPLACE (State or country): U. S.

(8) How long in U. S. (if of foreign birth): Life
(8B) How long resident in City of New York: Life

PARENTS OF DECEASED

10 NAME OF FATHER: Edward Goodchild
11 BIRTHPLACE OF FATHER (State or country): U. S.
12 MAIDEN NAME OF MOTHER: Josephine Walsh
13 BIRTHPLACE OF MOTHER (State or Country): U. S.

Special INFORMATION required in deaths in hospitals and institutions and in deaths of non-residents and recent residents.

Former or usual residence: 787 Columbus Ave.
Where disease contracted, if not at place of death

15 DATE OF DEATH
September 3 (Month) (Day), 1931 (Year)

16 *I hereby certify that the foregoing particulars (Nos. 1 to 15 inclusive) are correct as near as the same can be ascertained, and I further certify that deceased was admitted to this institution on* September 2 1931, *that I last saw him alive on the* 3rd *day of* September 1931, *that he died on the* 3rd *day of* September 1931, *about* 4.33 *o'clock A. M. or P. M., and that I am unable to state definitely the cause of death; the diagnosis during h last illness was:*

Acute intestinal obstruction

..... duration ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) .....
..... duration ..... yrs. ..... mos. ..... ds.

Witness my hand this ..... day of ..... 19.....
Signature James Kaplan M.D.
House Surgeon

17 *I hereby certify that I have this ..... day of ..... 19..., performed an autopsy upon the body of said deceased, and that the cause of h death was as follows:*

.....

Signature ..... M. D.

Pathologist ..... Hospital

FILED 8/61

18 PLACE OF BURIAL Calvary Cem.

DATE OF BURIAL Sep 7 1931

19 UNDERTAKER Hugh J. O'Neill

ADDRESS [illegible]

custody.

James A. Scanlon
CITY REGISTRAR

The Department of Health does not certify to the truth of the statements made thereon, as no inquiry as to the facts has been provided by law.

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