

FILED FEB 24 1945

Registration District No. 177

Primary Registration District No. 5569

Registrar's No. 188

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City Broad Branch
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
R#2 Woodhaven Addition
(If not in hospital or institution, write street number or location)
XX
(d) Length of stay: In hospital or institution 44 years (Specify whether years, months or days)
In this community 44 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. R#2 Woodhaven Addition
(If rural, give location)
N5
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT MRS. FANNIE GOOD
FULL NAME

3. (b) If veteran, name war XX 3. (c) Social Security No. No

4. Sex Fe / 5. Color or race Wh 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Wallace Good 6. (c) Age of husband or wife if alive 78 years

7. Birth date of deceased March 16 1867
(Month) (Day) (Year)

8. AGE: Years 77 Months 10 Days 21 If less than one day hr. _____ min. _____

9. Birthplace Haves County Texas
(City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business S.C. Glascock

12. Name No Record 9

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

14. Maiden name No Record 9
(City, town, or county) (State or foreign country)

16. (a) Informant Wallace Good

(b) Address R#2 Woodhaven Addition

17. (a) Burial (b) Date thereof 2-9-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah

18. (a) Signature of funeral director J.W. Wagner
(b) Address Kansas City, Mo.

19. (a) 2/8/45 (b) Richard Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 7th year 1945 hour 6: minute 10 PM A.

21. I hereby certify that I attended the deceased from Feb 4th to Feb 7th 1945
that I last saw her alive on Feb 7th 1945
and that death occurred on the date and hour stated above.
Immediate cause of death Uremia 45 yrs

Due to Cerebral Hemorrhage 6 da

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

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 _____

23. Signature Richard Brown (M. D. or other) Mo
Address 1115 1/2 Date signed 2-8-45

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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1159

Registration Office

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 Cecil P. Matthes

Licensed Embalmer No. 5807

P. O. Address. Kansas City, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. March
Registrar's No. 188

Registration District No. 147 Primary Registration District No. 5569

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Rural Brookings
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (c) PRINT FULL NAME

Jannie Good

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased March 16 1886
(Month) (Day) (Year)

8. AGE:

Years 77 Months _____ Days _____
If less than one day, _____ min.

9. Birthplace _____
(City, town, or county)

Texas
(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER } 12. Name _____

13. Birthplace _____
(City, town, or county)

(State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county)

(State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 7
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

Due to Metastasis - Probably Secondary
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Dr. J. H. Hoffer (M.D. or other) _____
Address _____ Date signed 2-28-45

SUPPLEMENTARY

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

60288