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

FILED APR 26 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11857

BIRTH NO. _____ REG. DIST. NO. 73 PRIMARY REG. DIST. NO. 3291 Registrar's No. 31

1. PLACE OF DEATH
a. COUNTY: Clay
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Liberty, Mo.
c. LENGTH OF STAY (in this place): 5 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Odd Fellows Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Clay 24
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Excelsior Springs 2 1
d. STREET ADDRESS (If rural, give location): 411 Isley Avenue 0

3. NAME OF DECEASED (Type or Print)
a. (First): ANNA
b. (Middle): GOODING
c. (Last): MCGINNESS

4. DATE OF DEATH (Month) (Day) (Year): April 17, 1949

5. SEX: Female 1
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: May 2, 1860
9. AGE (In years last birthday): 88 — IF UNDER 1 YEAR: Months 11, Days 15 — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Holt County, Missouri 0
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Robert Gooding
13b. MOTHER'S MAIDEN NAME: Amanda Janes
14. NAME OF HUSBAND OR WIFE: James Hale McGinness

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME — ADDRESS: Cassie Brock, Rt.#3, Liberty, Mo.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Fracture of femur — 12 days

19a. DATE OF OPERATION: 4-9-49
19b. MAJOR FINDINGS OF OPERATION: Fracture rt. femur - subtrochanteric
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street
21c. (CITY, TOWN, OR TOWNSHIP): Liberty — (COUNTY): Clay — (STATE): Mo.
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 4-5-49-12:10 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: Pt. fell while walking on sidewalk

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. *I hereby certify that I attended the deceased from* 4 April, 1949, *to* 17 April, 1949, *that I last saw the deceased alive on* 17 April, 1949, *and that death occurred at* 2:15 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): F. M. Waterman, M.D.
23b. ADDRESS: Liberty, Mo.
23c. DATE SIGNED: 17 April 49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Apr. 19, 1949
24c. NAME OF CEMETERY OR CREMATORY: Fairview
24d. LOCATION (City, town, or county) (State): Kearney, Mo.

DATE REC'D BY LOCAL REG.: APRIL 19 1949
REGISTRAR'S SIGNATURE: Minnie Haynes. 64 0
25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Claude Pritchard, Ex Springs, Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8.
District File Number
Filed 4-25-49

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~~ ..... Student Embalmer No. .....
working under my personal supervision.

Signed Lindell K. Jarman

Signed .....
Student Embalmer

Licensed Embalmer No. 4589

P. O. Address Excelsior Spring

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.