

FILED MAY 26 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15267
State File No. _____

24
1

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

BIRTH NO. _____ REG. DIST. NO. 71 PRIMARY REG. DIST. NO. 3014 Registrar's No. 56

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Excelsior Springs</u>		c. LENGTH OF STAY (In this place) <u>20 yrs</u>	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Excelsior Springs</u>		d. STREET ADDRESS (If rural, give location) <u>305 W. Excelsior</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>305 W. Excelsior</u>		3. NAME OF DECEASED a. (First) <u>Frank</u> b. (Middle) _____ c. (Last) <u>Goode</u>	
4. DATE OF DEATH <u>May 11, 1949</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Sept. 5, 1881</u>	
9. AGE (In years last birthday) <u>67</u>		10. KIND OF BUSINESS/OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Orrick, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>John H. Goode</u>		13b. MOTHER'S MAIDEN NAME <u>Mary E. Ralph</u>	
14. NAME OF HUSBAND OR WIFE <u>Amy Goode</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>William Goode, Rt. #1, Orrick, Mo.</u>	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>myocardial infarction acute, multiple</u> DUE TO (c) <u>coronary thrombosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>No</u>	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____		22. I hereby certify that I attended the deceased from <u>6-1</u> , 19 <u>48</u> , to <u>5-11</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>5-11</u> , 19 <u>49</u> , and that death occurred at <u>9:30A</u> m., from the causes and on the date stated above.	
23a. SIGNATURE <u>David Whisnault M.D.</u> (Degree or title)		23b. ADDRESS <u>Excelsior Springs, Mo</u>	
23c. DATE SIGNED <u>5-11-49</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>May 14, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	
24d. LOCATION (City, town, or county) (State) <u>Rural, Ex. Springs, Mo.</u>		DATE REC'D BY LOCAL REG. <u>5/12/49</u>	
REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Clara Trichard</u> ADDRESS <u>Ex. Springs, Mo.</u>	

MAY 17 REC'D
RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed _____

5-25-49

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 _____

E. E. White

Signed _____

Student Embalmer

Licensed Embalmer No. 4168

P. O. Address _____

Excelsior Springs, 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.