

FILED FEB 10 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1134

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 249

1. PLACE OF DEATH a. JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). STATE MISSOURI COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		c. LENGTH OF STAY (In this place) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION GENERAL HOSPITAL #2		d. STREET ADDRESS (If rural, give location) 620 Charlotte Street	

3. NAME OF DECEASED (Type or Print)	a. (First) CINDY	b. (Middle)	c. (Last) GOLDEN	4. DATE OF DEATH (Month) (Day) (Year) JANUARY 14 1951
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5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH MARCH 16 1881	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) AUSTIN, TEXAS	12. CITIZEN OF WHAT COUNTRY? U. S.
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13a. FATHER'S NAME CHARLIE CALDWELL	13b. MOTHER'S MAIDEN NAME MIRAH PATTERSON	14. NAME OF HUSBAND OR WIFE FRANK GOLDEN
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If res. give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME LAURA REED	ADDRESS 620 Charlotte Street
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARCINOMA OF CERVIX WITH METASTASIS		INTERVAL BETWEEN ONSET AND DEATH
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	ANTECEDENT CAUSES		
	Morbidity 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 ASCITES & HYDROTHORAX (RT) PULMONARY ATELECTASIS		171X
	Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT (Specify) SUICIDE HOMICIDE	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 1-8- 1951, to 1-14- 1951, that I last saw the deceased alive on 1-14- 1951, and that death occurred at 7:30 P m., from the causes and on the date stated above.

22a. SIGNATURE E. Frank Ellis (Degree or title) MD	23b. ADDRESS 600 East 22nd Street	23c. DATE SIGNED 1-17-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1-17-51	24c. NAME OF CEMETERY OR CREMATORY Highland	24d. LOCATION (City, town, or county) (State) K. C. Mo.
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DATE REC'D BY LOCAL REG. 1-17-51	REGISTRAR'S SIGNATURE Seraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE E. Sterling Bills	ADDRESS K. C. Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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_____

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working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

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.