

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **33070**

FILED NOV 8 - 1954

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>1144</u>	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (in this place) <u>15 yrs</u>		c. CITY OR TOWN <u>St. Joseph</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Missouri Methodist Hospt.</u>				e. STREET ADDRESS (If rural, give location) <u>2619 Mitchell Ave.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Amelia</u> b. (Middle) <u>Hi.</u> c. (Last) <u>Good</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 31, 1954</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Dec. 20, 1882</u>		9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Kansas City, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13a. FATHER'S NAME <u>George M. Koehler</u>		13b. MOTHER'S MAIDEN NAME <u>Julia Anna Glassner</u>		14. NAME OF HUSBAND OR WIFE <u>Frank J. Good Sr.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Gladys Bhoton, Greenfield, Ohio</u> ADDRESS _____			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Enterocolitis, non-specific</u> 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. <u>Acute Cholecystitis, secondary to a fever</u>					INTERVAL BETWEEN ONSET AND DEATH <u>21 days</u> <u>12 days</u>	
19a. DATE OF OPERATION <u>10-25-54</u>		19b. MAJOR FINDINGS OF OPERATION <u>Acute Cholecystitis</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>5711</u>			
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>10-19, 1954</u> to <u>10-30, 1954</u> , that I last saw the deceased alive on <u>10-30, 1954</u> and that death occurred at <u>2:00 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>John R. McDaniel, M.D.</u>				23b. ADDRESS <u>902 Elmwood St. St. Joseph</u>		23c. DATE SIGNED <u>11-1-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Nov. 2, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mound Grove Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Independence, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Nov 3, 1954</u>		REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Clark Funeral Home</u> ADDRESS <u>St. Joseph, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

Student.....
Signature of Student Embalmer

Signed.....
Emil A. Clark

Licensed Embalmer No. *422*

P. O. Address *St. Joe*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.