THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

24565

STATE FILE NUMBER

FILED AUG 12 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3406

1. PLACE OF DEATH
a. COUNTY JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) MENORAH MEDICAL CENTER — Length of stay in 1b 2 yrs 73 8/9

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTY JACKSON
c. CITY OR TOWN KANSAS CITY — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside give location) LOCARNO APTS 235 WARD PARKWAY — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First HAZEL Middle V. Last GOODWIN

4. DATE OF DEATH Month 7 Day 18 Year 1957

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH FEB-14-1891

9. AGE (In years last birthday) 66 — 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) HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY ------

11. BIRTHPLACE (City and state or country) TOPEKA KANSAS

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME unknown

14. MOTHER'S MAIDEN NAME unknown

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 PHILIP A. GOODWIN Address 235 WARD PARKWAY KANSAS CITY, MO

MEDICAL CERTIFICATION

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

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute massive cerebral hemorrhage, left frontal lobe.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____

INTERVAL BETWEEN ONSET AND DEATH: 331 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 7-18-57, to 7-18-57 and last saw her/him alive on 7-18-57
Death occurred at ____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Richard A Twyman MD.

22b. ADDRESS 4635 Wyandotte, KC. Mo

22c. DATE SIGNED 7-19-57

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

23b. DATE JULY 20 1957

23c. NAME OF CEMETERY ~~OR CREMATORY~~ MT. MORIAH CEMETERY

23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI

24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS ADDRESS 331 BRUSH CREEK KANSAS CITY, MO.

25. DATE RECD. BY LOCAL REG. 7-20-57

26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Richard A. Twyman, M.D.

VN 1-8886

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was en

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Robert Ray

Licensed Embalmer No. 41

P. O. Address K. C. M

KP 4

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.