

Health,
& Welfare
Public
Service

FILED MAY 2 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-014193
STATE FILE NUMBER
1855

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1855

300
1-57

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If in institution: Residence before admission) a. STATE MISSOURI b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V A HOSPITAL		Length of stay in lb 14 years	d. STREET ADDRESS (If outside, give location) 2407 HIGHLAND Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last EDWARD LA RUE GOODE			4. DATE OF DEATH Month Day Year April 7, 1958		
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 2, 1892	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Slater, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME David Goode	13b. MOTHER'S MAIDEN NAME Lutie Stewart	14. NAME OF HUSBAND OR WIFE Helen Goode
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) Yes WWI	16. SOCIAL SECURITY NO. 493 12 4558	17. INFORMANT Address VA Hospital Official Records, K. C. Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest during right upper lobe lobectomy		INTERVAL BETWEEN ONSET AND DEATH 1621
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c) Bronchogenic carcinoma of the upper lobe of the right lung with metastasis to adrenals & right kidney	
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 <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from March 3, 1958 to April 7, 1958 Death occurred at 10:54 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) ROBERT FLINNER, M.D.	22b. ADDRESS VA Hospital, Kansas City, Mo.	22c. DATE SIGNED 4-7-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/12/58	23c. NAME OF CEMETERY OR CREMATORY Slater Mo	23d. LOCATION (City, town, or county) (State) Slater Mo
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24. FUNERAL DIRECTOR ADDRESS Manlove Williams 1729 Lydia	25. DATE RECD. BY LOCAL REG. 4-11-58	26. REGISTRAR'S SIGNATURE neva minshall
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

doctor, coroner, etc. must use only standard nomenclature in their reports. No symptoms will be listed. All diseases in Part I must be causally related.



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 *D. J. Manlove*

 Licensed Embalmer No. 3994
 P. O. Address 3712 E 30th

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 *D. J. Manlove*

 Licensed Embalmer No. 3994
 P. O. Address 3712 E 30th

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.