

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-021852**

FILED JUL 9 1959 150

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STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Rural Prairie</b>		Length of stay in 1b <b>8 days</b>	c. CITY OR TOWN <b>Independence</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jackson County Hosp.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>10700 E. 28th.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>Edward Goldsworthy</b>	First Middle Last	4. DATE OF DEATH <b>July 1 1959</b>	Month Day Year
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4/3/1887</b>	9. AGE (last birthday) <b>72</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet metal</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Furnance</b>	11. BIRTHPLACE (City and state or country) <b>Huron, S. Dakota</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>A.L. Goldsworthy</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah E. Finley</b>	14. NAME OF HUSBAND OR WIFE <b>Leona H. Goldsworthy</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>490-09-2179</b>	17. INFORMANT <b>Leona H. Goldsworthy, Indep. Mo</b>	Address
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Heart disease</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>generalized arterio sclerosis</b>	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m. Month, Day, Year	
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20d. INJURY OCCURRED WHILE AT WORK <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 <b>Independence</b>	COUNTY <b>Jackson</b>	STATE <b>Missouri</b>
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21. I attended the deceased from **6-23-59** to **7-1-59** and last saw her alive on **7-1-59**  
Death occurred at **10:40 P.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Philip Saper M.D.</b>	(Degree or title)	22b. ADDRESS <b>Leis Summit, Mo</b>	22c. DATE SIGNED <b>7/2/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>7-3-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills Cem</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City MO</b>
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24. FUNERAL DIRECTOR <b>Floral Hills Chapel A.C. Mo</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>7-3-1959</b>	26. REGISTRAR'S SIGNATURE <b>D.B. Langford</b>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Forrest D. Cold*

Licensed Embalmer No. *4717*  
P. O. Address *KC Mo*

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