

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-006759

FILED VS. MAR. 9 1960 150

Primary Registration District No. 5572 Registrar's No. 67

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		Length of stay in 1b 20 yrs		c. CITY OR TOWN Independence		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jackson Co. Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1918 1/2 Vermont		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Gertrude Georgia Godier				4. DATE OF DEATH Month Day Year 3 2 1960			
5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 1 31 1876	9. AGE (last birthday) 84	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR 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 Domestic		11. BIRTHPLACE (City and state or country) Illinois		12. CITIZEN OF WHAT COUNTRY U. S. A	
13a. FATHER'S NAME Harvey Miller			13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Julius R. Godier		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No <input type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mrs. Elsie Mattson 1918 1/2 Vermont			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease</i> DUE TO (b) <i>Generalized arteriosclerosis</i> DUE TO (c) <i>Generalized arteriosclerosis</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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.)					
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.							
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		COUNTY	STATE
21. I attended the deceased from 2-24-60 to 3-2-60 and last saw her alive on 3-2-60 Death occurred at 2:45 pm on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Philip Jager M.D.</i>				22b. ADDRESS <i>Lees Summit Mo</i>		22c. DATE SIGNED <i>3/2/60</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-4-1960	23c. NAME OF CEMETERY OR CREMATORY Floral Hills		23d. LOCATION (City, town, or county) (State) Kansas City Missouri		
24. FUNERAL DIRECTOR Floral Hills Memorial Chapels, Inc			ADDRESS K.C. Mo		25. DATE RECD. BY LOCAL REG. 3-4-1960	26. REGISTRAR'S SIGNATURE <i>D. B. Longford</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Forrest D. Goldenow

Licensed Embalmer No. 4714

P. O. Address LCU

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