

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 14 1960

-60-030944

Registration District No. 146 Primary Registration District No. 5568 Registrar's No. 830

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Blue Twp</u>		Length of stay in 1b <u>0</u>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>71 Bypass at Liberty Bridge</u>				Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>714 Virginia</u>	
3. NAME OF DECEASED (Type or print) First <u>Merlin</u> Middle <u>E.</u> Last <u>Goff</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>4</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10-2-1910</u>	9. AGE (last birthday) <u>49</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Furnace Operator</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Union Wire & Rope</u>		11. BIRTHPLACE (City and state or country) <u>Livingston Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Charles Goff</u>			13b. MOTHER'S MAIDEN NAME <u>Margaret Brier</u>			14. NAME OF HUSBAND OR WIFE <u>Mrs. Mabel Goff</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW 2</u>		16. SOCIAL SECURITY NO. <u>486-30-1285</u>		17. INFORMANT Address <u>Mrs. Mable Goff Kansas City, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull crushed chest</u> DUE TO (b) <u>chest</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>History of Inspiration</u> 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						INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Driver of one car which</u>					
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ <u>9 4 60</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. CITY, TOWN, OR LOCATION <u>Jackson</u>		
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____	Death occurred at <u>5:00</u> a _____ m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>Hugh A. Carson</u>			22b. ADDRESS <u>152 Union Station</u>			22c. DATE SIGNED <u>9-5-60</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-8-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wheeling Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Wheeling Missouri</u>		
24. FUNERAL DIRECTOR <u>Geo. C. Carson & Sons</u>			ADDRESS <u>Independence, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>9-8-60</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 16 1960

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.