

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034751

FILED VS. SEP 20 1960

149

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. _____

4523

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>Mo</u> b. COUNTY <u>Jackson</u>							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in lb <u>2 yrs</u>		c. CITY OR TOWN <u>Blue Springs</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>Haven Manor Rest Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1404 B Street</u>		Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Leanna</u> Middle <u>Belle</u> Last <u>Gaines</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>3</u> Year <u>1960</u>							
5. SEX <u>Fm</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2/27/1872</u>		9. AGE (last birthday) <u>88</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>Retired housekeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Anderson Indiana</u>		11. BIRTHPLACE (City and state or country) <u>USA</u>	
13a. FATHER'S NAME <u>Robert Goodwin</u>				13b. MOTHER'S MAIDEN NAME <u>Nancy Carter</u>				14. NAME OF HUSBAND OR WIFE <u>Deceased</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Winnie Hofer</u>				Address <u>Blue Springs 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>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>1 yr 4 mos.</u>			
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"/> N. <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 _____ a.m. _____ p.m.		Month, Day, Year _____									
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 <u>Oct 11, 1958</u> to <u>Sept 3 1960</u> and last saw her <u>Sept 3 1960</u> Death occurred at <u>11:05 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Doctor or title) <u>W. H. Goodson, M.D.</u>				22b. ADDRESS <u>730 Professional Bldg Kansas City Mo</u>				22c. DATE SIGNED <u>9/3/60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Sept 6 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Higginsville Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Higginsville Mo</u>					
24. FUNERAL DIRECTOR <u>Webb Funeral Home</u>				ADDRESS <u>Blue Springs Mo</u>		25. DATE RECD. BY LOCAL REG. <u>9-5-60</u>		26. REGISTRAR'S SIGNATURE <u>H. L. Sawyer</u>			

DOCUMENT

BY AFIDAVIT OF Wm. H. Goodson, Medical Certification

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 William Fries

Licensed Embalmer No. 473
P. O. Address Blue Springs

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.