JRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

60-038370

STATE FILE NUMBER

FILED VS OCT 31 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5203

NDED

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City
Length of stay in 1b 1 day
c. FULL NAME OF HOSPITAL OR INSTITUTION St Luke Hosp.
Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Jackson
c. CITY OR TOWN Lees Summit
Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 400 Madison
Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Infant Middle Goodrich Last
4. DATE OF DEATH Month 10 Day 15 Year 60

5. SEX Female
6. COLOR OR RACE W
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 10-14-60
9. AGE (last birthday) —
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) Baby
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Kansas City Mo
12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Clarence Goodrich
13b. MOTHER'S MAIDEN NAME Rebecca Dancer
14. NAME OF HUSBAND OR WIFE —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Clarence Goodrich Address Lees Summit Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Atelectasis, Bilateral
INTERVAL BETWEEN ONSET AND DEATH 1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Prematurity
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Oct. 14, 1960, to Oct. 15 1960 and last saw her alive on 10-15-1960
Death occurred at 3:00 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Clint L. Miller (Degree or title) MD
22b. ADDRESS Lees Summit Mo
22c. DATE SIGNED 10-16-60

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 10/17/60
23c. NAME OF CEMETERY OR CREMATORY Lees Summit
23d. LOCATION (City, town, or county) Lees Summit (State) Mo

24. FUNERAL DIRECTOR Langford Funeral Home ADDRESS Lees Summit
25. DATE RECD. BY LOCAL REG. 10-17-60
26. REGISTRAR'S SIGNATURE H. L. Dwyer

(License Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF Clint L. Miller 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

or by Not Embalmed, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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