

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

**-60-046081**

**FILED VS DEC 19 1960**

*149*

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

**6064**

STATE FILE NUMBER

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY <b>JACKSON</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b> Length of stay in lb <b>64 years</b> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3615 Campbell Street</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b> c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>3615 Campbell Street</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> First Middle Last <b>JULIUS C. GOLDMAN</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>December 2, 1960</b>		
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>8-27-1877</b>	<b>9. AGE (last birthday)</b> <b>83</b>	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>CLOTHING</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Liberty, Missouri</b>	
<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>		<b>13a. FATHER'S NAME</b> <b>Manheim Goldman</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Henrietta Beatus</b>	
<b>14. NAME OF HUSBAND OR WIFE</b> <b>Florence Goldman</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>	
<b>17. INFORMANT</b> <b>CLYDE J. LINDE</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subdural Hemorrhage</i> DUE TO (b) <i>Cerebral Edema</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>20a. ACCIDENT</b> <input checked="" type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) <i>Fell in bathroom at home</i>	
<b>20c. TIME OF INJURY</b> Hour Month, Day, Year a.m. p.m. <i>11-30-60</i>		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	
<b>20f. CITY, TOWN, OR LOCATION</b> <b>Kansas City, Missouri</b>		<b>21. I attended the deceased from _____, to _____ and last saw him alive on _____</b> Death occurred at <b>1:20 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.		<b>22c. DATE SIGNED</b> <b>12-3-60</b>	
<b>22a. SIGNATURE</b> (Degree or title) <i>Paul K. Coffey, Jr. Deputy Coroner</i>		<b>22b. ADDRESS</b> <b>6627 Parkside Dr. Overland Park, Mo.</b>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>CREMATION</b>	
<b>23b. DATE</b> <b>DEC. 3, 1960</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>D. W. NEWCOMER'S SONS</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>	
<b>24. FUNERAL DIRECTOR</b> <b>D. W. NEWCOMER'S SONS KANSAS CITY, MO.</b>		<b>25. DATE RECD. BY LOCAL REG.</b> <b>12-3-60</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>H. L. Dwyer</i>	

DOCUMENT

BY AFFIDAVIT OF C. Keelhofer 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 Vern Lawler

Licensed Embalmer No. 4915

P. O. Address K.C. Mo

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.