

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048706

FILED VS JAN 23 1961

149

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6597 STATE FILE NUMBER

DEED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Jackson</b>	a. STATE <b>Mo.</b>	b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>	Length of stay in 1b <b>52 yrs</b>	c. CITY OR TOWN <b>Kansas City</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Luke's Hosp.</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3214 Jefferson</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <b>MAUDE</b>	Middle <b>M.</b>	Last <b>GOOD</b>	4. DATE OF DEATH	Month <b>12</b>	Day <b>30</b>	Year <b>60</b>
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5. SEX <b>Fe</b>	6. COLOR OR RACE <b>Wh</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8-18-78</b>	9. AGE (last birthday) <b>82</b>	IF UNDER 1 YEAR Months <b>12</b> Days <b>30</b>	IF UNDER 24 HR Hours <b>60</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Joseph, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA.</b>
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13a. FATHER'S NAME <b>James Collins</b>	13b. MOTHER'S MAIDEN NAME <b>M.</b> <b>Mary Ann Collins</b>	14. NAME OF HUSBAND OR WIFE <b>Percy E. Good</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mrs. Dorothy Maxey, 3214 Jeff. KC Mo</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:	INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Transition</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
DUE TO (b) <b>Carcinomatosis</b>	
DUE TO (c) <b>Carcinoma of Stomach</b>	
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"/> 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.)
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20c. TIME OF INJURY Hour <b>2:30</b> a.m. Month, Day, Year <b>1958</b>	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.)	20f. CITY, TOWN, OR LOCATION <b>Kansas City</b>	COUNTY <b>Mo.</b>	STATE
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21. I attended the deceased from **2:30 A.M. 1958** to **12-30-60** and last saw her/him alive on **12-29-60**  
Death occurred at **2:30 A.M. 1958** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>R. K. Skillman M.D.</b>	(Degree or title)	22b. ADDRESS <b>4635 Lyndette, KC, Mo</b>	22c. DATE SIGNED <b>12-30-60</b>
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23a. BURIAL, CREMATION, REMOVAL (specify) <b>Burial</b>	23b. DATE <b>12-31-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) <b>Kansas City</b>	(State) <b>Mo.</b>
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24. FUNERAL DIRECTOR <b>Magner Funeral Home, K C Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>12-30-60</b>	26. REGISTRAR'S SIGNATURE <b>H. L. Sawyer</b>
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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  
or by Phillip L. Smith, Student Embalmer No. 62

working under my personal supervision.

Student Phillip L. Smith  
Signature of Student Embalmer

Signed Alvin R. Haunscho

Licensed Embalmer No. 415

P. O. Address Hans

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.