No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44043

State File No. .....

FILED JAN 23 1952

BIRTH NO. ..... REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 3026 Registrar's No. 511

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH
a. COUNTY Jackson 0485
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Independence
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 117 E Linden

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).
a. STATE Missouri
b. COUNTY Jackson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Independence
d. STREET ADDRESS (If rural, give location) 117 E Linden

3. NAME OF DECEASED (Type or Print)
a. (First) Frank
b. (Middle) Fitch
c. (Last) Goodman

4. DATE OF DEATH (Month) (Day) (Year) Dec. - 30 - 51

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Nov 25 1876
9. AGE (In years last birthday) 75 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Stationary Engineer
10b. KIND OF BUSINESS OR INDUSTRY Retired
11. BIRTHPLACE (State or foreign country) Cass County Mo
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME George W Goodman
13b. MOTHER'S MAIDEN NAME Lavina Fitch
14. NAME OF HUSBAND OR WIFE Mary Goodman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 490-09-1698
17. INFORMANT'S SIGNATURE OR NAME Mrs Virgil McElroy ADDRESS Indep Mo

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 10 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 331X
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-20, 1951, *to* 12-30, 1951, *that I last saw the deceased alive on* 12-30, 1951, *and that death occurred at* ..... *m., from the causes and on the date stated above.*

23a. SIGNATURE Fred J Hammar VDO (Degree or title)
23b. ADDRESS Indep. Mo.
23c. DATE SIGNED 12/31/51

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 1-2-52
24c. NAME OF CEMETERY OR CREMATORY Moral Hills Cem
24d. LOCATION (City, town, or county) (State) K C Mo

DATE REC'D BY LOCAL REG. Jan 2, 1952
REGISTRAR'S SIGNATURE Homer L Gray 3 Sy
25. FUNERAL DIRECTOR'S SIGNATURE A H Mitchell ADDRESS Indep Mo

(Licensed Embalmer's Statement on Reverse Side)

JAN 11 REC'D
VS MAY 27 1959
MAR 25 1955
MAR 12 1955

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

_____, working under my personal supervision.

~~Student~~ Embalmer No. _____

Signed _____

Licensed Embalmer No. 3156

P. O. Address Indep. Mo.

Signed _____
Student Embalmer

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 this body is not embalmed, fact should be so stated above.