

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43319

FILED JAN 8 1954

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 150 PRIMARY REG. DIST. NO. 5572 Registrar's No. 236

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, write RURAL and give township) <u>Grain Valley</u>		c. CITY OR TOWN <u>Grain Valley</u>	
c. LENGTH OF STAY (in this place) <u>Emergency Hos. 24hr</u>		d. Is residence within limits of a city or incorporated town? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Independence Rural Jackson Co Emergency Hosp</u>		e. STREET ADDRESS (If rural, give location) <u>3 Miles South Sni a bar T</u>	
3. NAME OF DECEASED (Type or Print) <u>Stephen E Goodrich</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 19 1953</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May-8-1901</u>
9. AGE (In years last birthday) <u>52</u>		10. IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Heavy Construction</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (City and State or Foreign Country) <u>Penn</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Perry Goodrich</u>		13b. MOTHER'S MAIDEN NAME <u>Lula Banker</u>	
14. NAME OF HUSBAND OR WIFE <u>Letha Goodrich</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>495-07-4993</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Letha Goodrich Grain Valley Mo</u>	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Respiratory Failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>(Spontaneous)</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertrophy of Heart</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>		19a. DATE OF OPERATION _____	
19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> 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) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE <u>Albert E. Ueber</u> (Degree or title) <u>MD</u>		23b. ADDRESS <u>909 Arroyo Bldg KC-MO</u>	
23c. DATE SIGNED <u>12/20/53</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>Dec 23 1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Hill</u>	
24d. LOCATION (City, town, or county) (State) <u>Pleasant Hill Mo</u>		DATE REC'D BY/LOCAL REG. <u>12/23/53</u>	
REGISTRAR'S SIGNATURE <u>NB Langford</u> <u>483</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Webb Funeral Home Blue Springs Mo</u>	

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

RECEIVED

JAN 8 1964

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *P B Webb*

Licensed Embalmer No. *2313*

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.