FILED AUG 1 - 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 24563

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3237

1. PLACE OF DEATH
a. COUNTY JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY — Inside Limits Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3018 FOREST AVE. — Length of stay in 1b 5 yrs. 3
d. STREET ADDRESS (If outside, give location) 3018 FOREST AVE — Reside on Farm Yes ☐ No X

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY JACKSON
c. CITY OR TOWN KANSAS CITY — Inside Limits Yes X No ☐

3. NAME OF DECEASED (Type or print): First WILLIAM Middle O. Last GOFF

4. DATE OF DEATH: Month July Day 11 Year 1957

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH MARCH 24 1877

9. AGE (In years last birthday) 80 — IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) CHILLICOTHE, MISSOURI

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME CHARLES F. GOFF

14. MOTHER'S MAIDEN NAME MARTHA ROSE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 497-32-3152

17. INFORMANT MRS. VELMA BENSON, Address 3018 FOREST K.C. MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Hypertension
DUE TO (c) Senility — 331 A

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐ 2

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 1955 to July 11-57 and last saw ~~her~~ him alive on July 10-57
Death occurred at 2:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Hugh A. Gestring M.D. (Degree or title)

22b. ADDRESS 1220 E 31st KC Mo

22c. DATE SIGNED 7-11-57

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL

23b. DATE July 11, 1957

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county) CHILLICOTHE (State) MISSOURI

24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS ADDRESS KANSAS City, Mo.

25. DATE RECD. BY LOCAL REG. 7-11-57

26. REGISTRAR'S SIGNATURE Nova Minshall

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Hugh A. Gestring, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Albert L Savage.....

Licensed Embalmer No. 48

P. O. Address Kansas

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