

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001432

FILED VS. FEB. 1 1960 149

271

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Length of stay in 1b <u>unknown</u>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR NURSING HOME <u>River View Nursing Home</u> INSTITUTION <u>540 Highland</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>540 Highland</u>	
3. NAME OF DECEASED (Type or print) First <u>DAFF</u> Middle <u>BUYTON</u> Last <u>BUYTON</u>			4. DATE OF DEATH Month <u>1</u> Day <u>15</u> Year <u>60</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8/1/1882</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>National Paper Box Shannon Co mo</u>		11. BIRTHPLACE (City and state or country) <u>U. S. A.</u>		
13a. FATHER'S NAME <u>No Record</u>		13b. MOTHER'S MAIDEN NAME <u>No Record</u>		14. NAME OF HUSBAND OR WIFE <u>UNK</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>499-18-1466A</u>	17. INFORMANT <u>May Goss</u> Address <u>Blanche Goss 435 Gladstone</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Atherosclerosis</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
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.)			
20c. TIME OF INJURY Hour <u> </u> Month, Day, Year <u> </u> a.m. <u> </u> p.m. <u> </u>		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		COUNTY		STATE	
21. I attended the deceased from <u>1-7-59</u> to <u>1-15-60</u> and last saw her/him alive on <u>1-15-60</u> Death occurred at <u>11 A. M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Robert F. Goodwin M.D.</u>			22b. ADDRESS <u>7228 Beverly Overland Park Mo</u>		22c. DATE SIGNED <u>1-15-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1-19-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY KANSAS</u>			
24. FUNERAL DIRECTOR <u>John P. Shev</u>		ADDRESS <u>K.C. Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>1-18-60</u>	26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
Robert F. Goodwin

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 Richard E. Carroll

Licensed Embalmer No. 4829

P. O. Address A. C. Sw

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.