

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-038604

5524

STATE FILE NUMBER

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

DO NOT WRITE ON THIS STUB AMENDED

FILED NOV 9 1962

VS 300 Rev. 4/59	1	23958	3	4 0	5 1	6	7 1	8 2	9527.1	10	11	1290-0	13
DATE AMENDED		INSTEAD OF		DOCUMENT		MEDICAL CERTIFICATION		BY AFFIDAVIT OF		AMENDMENTS ON THIS RECORD ARE AS FOLLOWS		SHOULD READ	
Wendell L. Good													

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI , b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS City		Length of stay in 1b 60 year.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 8044 OLIVE		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE ROSCOE BROWN		4. DATE OF DEATH Month OCTOBER Day 30 Year 1962	
5. SEX MALE	6. COLOR OR RACE CAUC.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH MAR. 1, 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY MEGR. AGENT	9. AGE (last birthday) 64 years
11. BIRTHPLACE (City and state or country) STILLWELL, KANSAS		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME CHARLES F. BROWN		13b. MOTHER'S MAIDEN NAME -	
14. NAME OF HUSBAND OR WIFE MARGUERITE BROWN		Address 8044 OLIVE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -	
17. INFORMANT MRS. MARGUERITE BROWN		Address 8044 OLIVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left ventricular failure myocardial insufficiency DUE TO (b) cor pulmonale DUE TO (c) chronic pulmonary emphysema			INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 1 1/2 - 2 yrs. 12 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Benign Prostatic Hypertrophy.			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 _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input 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 August 1961 to Oct. 30, 1962 and last saw ^{her} him alive on October 18, 1962 Death occurred at 9:55 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Wendell L. Good M.D.		22b. ADDRESS 5832 Reeds Rd. Mission, Kansas	
22c. DATE SIGNED 10-30-62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov. 2, 1962	23c. NAME OF CEMETERY OR CREMATORY ST MARYS CEMETERY	23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
24. FUNERAL DIRECTOR MUEHLEBACH		ADDRESS 6800 TROOST	
25. DATE RECD. BY LOCAL REG. 10-31-62		26. REGISTRAR'S SIGNATURE Ruth Long	

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Wendell Good
5832 Reeds - Rd.

HE 20230
TUES.
2-5 WED.

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

Robert J. Landis

Licensed Embalmer No.

5103

P. O. Address

K.C., Mo

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.