

FILED DEC 9 1947

State File No. _____

Registration District No. 146

Primary Registration District No. 3026

Registrar's No. 351

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

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Independence
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Independence Sanitarium
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 6 hours (Specify whether
3 months
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME MRS. MYRTLE MAY GOSSETT
 (b) If veteran, name war none
 (c) Social Security No. none

4. Sex female 5. Color or race white
 6. (a) Single, widowed, married, divorced married
 (b) Name of husband or wife F. B. Gossett
 (c) Age of husband or wife if alive 69 years
 7. Birth date of deceased Feb. 11, 1879
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 9 13 hr. min.

9. Birthplace Dade County, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business _____

MOTHER FATHER { 12. Name J. T. Wilson
 13. Birthplace Dade County, Mo.
(City, town, or county) (State or foreign country)

{ 14. Maiden name Martina Moon
 15. Birthplace Dade County, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant F. B. Gossett
 (b) Address RFD 1, Independence, Mo.

17. (a) Burial (b) Date thereof 11 26 47
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Goodman Cem.

18. (a) Signature of funeral director Geo. C. Gaiser
Independence, Mo.
 (b) Address _____

19. (a) 11-28-47 (b) Sam Craig
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Independence
(If outside city or town limits, write "RURAL")
 (d) Street No. RFD #1
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 24
 year 1947 hour 7:55 minute P M.

21. I hereby certify that I attended the deceased from Nov. 24
 1947, to Nov 24, 1947
 that I last saw her alive on Nov 24, 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cerebral hemorrhage
arterio sclerosis
 Due to _____
 Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
 Of autopsy _____
BP

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature Sam Craig (M.D. or other) _____
 Address Independence Mo Date signed 11-28-47

Duration 18 hr
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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.....

William H. Schenker

Registered Apprentice No.

439

working under my personal supervision.

Signed.....

R. A. Lisle

Licensed Embalmer No.

4123

P. O. Address.....

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