

FILED JUN 10 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 15885

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2171

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, write RURAL and give OR TOWN Kansas City)		c. CITY (If outside corporate limits, write RURAL and give township) STAY (in this place) 34 yrs	
d. FULL NAME OF HOSPITAL OR INSTITUTION K.C. General hospital No. 1		d. STREET ADDRESS (If rural, give location) 5404 Virginia	

3. NAME OF DECEASED (Type or Print) a. (First) Henry b. (Middle) G. c. (Last) Gosting	4. DATE OF DEATH (Month) May (Day) 16th (Year) 1949
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5. SEX (M) MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH APR 27 1873	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months Days	IF UNDER 4 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRAFFIC MGR	10b. KIND OF BUSINESS OR INDUSTRY RETIRED	11. BIRTHPLACE (State or foreign country) IOWA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME ALFRED W. GOSTING	13b. MOTHER'S MAIDEN NAME MARY ANN GUERIN	14. NAME OF HUSBAND OR WIFE PORTIAM. GOSTING
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 487-10-3150	17. INFORMANT'S SIGNATURE OR NAME (Address) Portia M. Gosting N.C. Mo
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute coronary occlusion with myocardial infarction		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of Bladder			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 5-16-49, 19\_\_, to 5-16-49, 19\_\_, that I last saw the deceased alive on 5-16-49, 19\_\_, and that death occurred 6:15 P. m., from the causes and on the date stated above.

23a. SIGNATURE Wm. W. Hart (Degree or title)	23b. ADDRESS Med. Dir. K.C. Gen. Hospital	23c. DATE SIGNED 5-17-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5-19-1949	24c. NAME OF CEMETERY OR CREMATORY MT MORIAH	24d. LOCATION (City, town, or county) (State) KANSAS CITY MO
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DATE REC'D BY LOCAL REG. 5-18-49	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE Mrs G. L. Foster	ADDRESS N.C. Mo
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(Licensed Embalmer's Statement on Reverse Side)

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

JUN 10 1943

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.....

.....  
working under my personal supervision.

..... Student Embalmer No. ....

Signed Paul Clark.....

Signed.....  
Student Embalmer

Licensed Embalmer No. 4716.....

P. O. Address K. Co. 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.