

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

FILED MAY 1 - 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1740

300
1-56

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
Arnold V. Arms M. D.

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|--|-------------------------------|---|--|--|--|--|---|---|--|
| 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 | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1112 W. 45 St. | | | Length of stay in lb Life | | d. STREET ADDRESS 1112 W. 45 St. | | (If outside, give location) Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Harold Middle Charles Last Gosnell | | | | 4. DATE OF DEATH Month April Day 12 Year 1957 | | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 20, 1890 | | 9. AGE (In years last birthday) 66 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cattle Buyer | | | 10b. KIND OF BUSINESS OR INDUSTRY A. J. Maure & Sons | | 11. BIRTHPLACE (City and state or country) Kansas City Mo. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Peter J. Gosnell | | | | 14. MOTHER'S MAIDEN NAME Cornelia Hamlin | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Mrs. Winifred Gosnell 1112 W. 45 St. | | | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia Left upper | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 days | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) Chronic Bronchitis + | | DUE TO (c) Pneumothorax | | 3 yrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Atherosclerosis | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 Month, Day, Year a. m. p. m. | | | | | | | | | |
| 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 Nov 27-54 to 4-12-57 and last saw her alive on 4-11-57 Death occurred at 7 AM m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Arnold V. Arms M.D. | | | | 22b. ADDRESS 4635 Wyandotte R. City Mo | | 22c. DATE SIGNED 4-12-57 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 4/15/57 | | 23c. NAME OF CEMETERY OR CREMATORY Forest Hill | | 23d. LOCATION (City, town, or county) Kansas City | | STATE Mo. | |
| 24. FUNERAL DIRECTOR Stine & McClure | | | | ADDRESS K. C. Mo. | | 25. DATE RECD. BY LOCAL REG. 4-15-57 | | 26. REGISTRAR'S SIGNATURE Alva Marshall | |

Je. 1-05522



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.....
J. T. Crowell

Licensed Embalmer No. 49

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.