

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-082536**  
STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 410

**FILED SEP 10 1963**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Jackson</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Independence</u> Length of stay in 1b <u>3 yrs.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> c. CITY OR TOWN <u>Independence</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>12400 E. 49th Street</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>12400 E. 49th Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print) First <u>Mrs. Nellie</u> Middle <u>S.</u> Last <u>Gossard</u>			<b>4. DATE OF DEATH</b> Month <u>September</u> Day <u>2</u> Year <u>1963</u>				
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>Caucasian</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Sept. 30, 1870</u>	<b>9. AGE (last birthday)</b> <u>92</u>	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HR</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>At Home</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Ohio</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U. S. A.</u>	
<b>13a. FATHER'S NAME</b> <u>Unknown</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>			<b>14. NAME OF HUSBAND OR WIFE</b> <u>  </u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			<b>16. SOCIAL SECURITY NO.</b> <u>  </u>			<b>17. INFORMANT</b> Address <u>Franklin A. Alexander, 4011 W. 90th Ter</u>	

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inanition and Debilitation</u> DUE TO (b) <u>Carcinomatosis</u> DUE TO (c) <u>Primary Carcinoma of Breast</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>2-3 yrs.</u> <u>5 yrs.</u>	
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	

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)		
<b>20c. TIME OF INJURY</b> Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> Month, Day, Year <u>  </u>		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE		

21. I attended the deceased from June 1960 to Sept. 2, 1963 and last saw <sup>her</sup> ~~him~~ alive on August 6, 1963  
 Death occurred at approximately 1:30 p m on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree and title) <u>Ernie Anderson Jr. D.O.</u>		<b>22b. ADDRESS</b> <u>4219 Blue Ridge Blvd. K.C. Mo.</u>		<b>22c. DATE SIGNED</b> <u>9-3-63</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Moriah</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Kansas City, Mo.</u>	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Stine &amp; McClure - K. C., Missouri</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>9-5-62</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Alba L. Craig</u>

DO NOT WRITE ON THIS STUB  
 AMENDED  
 VS 300 Rev. 4/59  
 1 7005  
 2 7005  
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 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
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9-5-1962

SEP 11 1962

Alv. Arp  
4219 Beave Ridge Blvd  
JL 3 - 77797  
10:30 - 10:45  
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STATEMENT BY LICENSED EMBALMER

8-08

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

*William M. Turner*

Licensed Embalmer No.

*4648*

P. O. Address

*Kansas City, 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.