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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 12 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27580

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 3238

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days (Specify whether years, months or days)

In this community 40 Years D

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson 041

(c) City or town: Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 6036 South Benton
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country ----

3. (a) PRINT FULL NAME: JOEL Finley GOSSAGE

3. (b) If veteran, name war: No

3. (c) Social Security No.: None

4. Sex: Male 0

5. Color or race: White 1

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Mrs. Lula May Gossage

6. (c) Age of husband or wife if alive: 76 years

7. Birth date of deceased: November (Month) 2 (Day) 1862 (Year)

8. AGE: Years 78 Months 9 Days 24 If less than one day ____ hr. ____ min.

9. Birthplace: Scottsburg (City, town, or county) Indiana 1 (State or foreign country)

10. Usual occupation: Special Officer-Retired

11. Industry or business: Street Railways Company

FATHER
12. Name: Joel Gossage
13. Birthplace: (City, town, or county) Kentucky 1 (State or foreign country)

MOTHER
14. Maiden name: Jane ~~Mahala~~ Mahala
15. Birthplace: (City, town, or county) Indiana 1 (State or foreign country)

16. (a) Informant: Mrs. Madge Gardner
(b) Address: 6035 Montgall

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug. 28, 1941 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt. Moriah Cemetery

18. (a) Signature of funeral director: O. H. Newcomer's Sons
(b) Address: 1401 Brush Creek Blvd.

19. (a) 8/28/41 (Date received local registrar) (b) M. M. Crow (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 26th year 1941 hour 3 minute 30 P. M.

21. I hereby certify that I attended the deceased from 8-24-41, 19__ to 8-26-41, 19__; that I last saw him alive on 8-26-41, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute hemorrhagic cystitis	
Due to: Prostatic hypertrophy	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations: 1 3 10
Of autopsy: See above

PHYSICIAN — Underline the cause to which death should be charged statistically.

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature: Drury C. Thom (M. D. or other) D
Address: Med. Dir. K.C. Gen. Hospital Date: 8-27-1941

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address K C Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

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