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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35512

FILED NOV 20 1948

State File No. _____

Registration District No. 6

Primary Registration District No. 3001

Registrar's No. 24

1. PLACE OF DEATH:

(a) County AUDRAIN
(b) City or town VANDALIA
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
407 W. WOODLAWN
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 62 yrs. years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County AUDRAIN 4
(c) City or town VANDALIA 2
(If outside city or town limits, write "RURAL")
(d) Street No. 407 W. WOODLAND 1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME EARL CLEVELAND GOSS

3. (b) If veteran, name war _____ 3. (c) Social Security No. 499-24-6218

4. Sex MALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife BESSIE GOSS
6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased AUG 20 1888
(Month) (Day) (Year)

8. AGE: Years 64 Months 2 Days 19
If less than one day _____ hr. _____ min.

9. Birthplace WOODLAND ILLINOIS
(City, town, or county) (State or foreign country)

10. Usual occupation BRICK TURNER

11. Industry or business WALSH REFR FARBER Mo.

12. Name WILLIAM TAYLOR GOSS

13. Birthplace CHILLICOTHE OHIO
(City, town, or county) (State or foreign country)

14. Maiden name EMMA PHILIPS

15. Birthplace BALIS ILLINOIS
(City, town, or county) (State or foreign country)

16. (a) Informant CLOYD GOSS

(b) Address VANDALIA, Mo.

17. (a) BURIAL (b) Date thereof 11-18-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation VANDALIA CEMETARY

18. (a) Signature of funeral director Blair B. Smith

(b) Address Vandalia, Mo.

19. (a) Nov 10 1948 (b) Mollie Fugate
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 8
year 1948 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from 5/28, 1948, to 11/6, 1948
that I last saw him alive on 11/6, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death uremic coma Duration 2 days

Due to chronic nephritis 2 yrs

Due to Primary carcinoma of
resecting colon &

Other conditions metastasis to spine 6 months
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____
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? _____

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

23. Signature Thos. L. Juyet, M.D. (attester)
Address Mexico, Mo. Date signed 11/8/48

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 11-48-197

Date Filed NOV 19 1948

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..... Clyde W. Wilkey.....

Licensed Embalmer No. 3826

P. O. Address Perry, 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.