

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **32315**

**FILED SEP 28 1950**

S. No. 300  
V. 10.48

0980

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

BIRTH NO. _____		REG. DIST. NO. <u>325</u>		PRIMARY REG. DIST. NO. <u>6096</u>		Registrar's No. <u>31</u>		
1. PLACE OF DEATH a. COUNTY <u>Schuyler</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Schuyler</u> <u>0980</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural (Glenwood) TWP</u>		c. LENGTH OF STAY (In this place) <u>40 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural (Glenwood)</u> <u>0</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				d. STREET ADDRESS (If rural, give location) _____				
3. NAME OF DECEASED (Type or Print) a. (First) <u>ERMA</u> b. (Middle) <u>LUILLIE</u> c. (Last) <u>GOSSER</u>			4. DATE OF DEATH <u>Sept. 17, 1950</u> (Month) (Day) (Year)					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>		8. DATE OF BIRTH <u>July 27, 1910</u>		
9. AGE (In years last birthday) <u>40</u>		if UNDER 1 YEAR Months _____ Days _____		if UNDER 2 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Missouri</u> <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Jacob O. Gosser</u>			13b. MOTHER'S MAIDEN NAME <u>Mallie Harris</u>		14. NAME OF HUSBAND OR WIFE <u>K</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mallie Gosser, Glenwood Mo</u> ADDRESS _____				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>		<p align="center"><b>MEDICAL CERTIFICATION</b></p> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Carcinoma Uterus - Adjacent organ</u> 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. _____					INTERVAL BETWEEN ONSET AND DEATH <u>7 Months</u>	
19a. DATE OF OPERATION <u>Nov. 16-1950</u>		19b. MAJOR FINDINGS OF OPERATION <u>Extensive Ca of Uterus &amp; Adjacent organ? lymph nodes</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) _____				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m. _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____				
22. I hereby certify that I attended the deceased from <u>May 1, 1950</u> , to <u>Sept 17, 1950</u> , that I last saw the deceased alive on <u>Sept 17, 1950</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.								
23a. SIGNATURE <u>Carl J. Kardon, M.D.</u> (Degree or title)				23b. ADDRESS <u>Saucaaster Mo</u>		23c. DATE SIGNED <u>9/18/50</u>		
24a. BURIAL / CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>9/19/1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Queen City Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Queen City Mo.</u>		
DATE REC'D BY / LOCAL REG. <u>9/18/50</u>		REGISTRAR'S SIGNATURE <u>Mrs. A. J. Drake</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. West</u>		ADDRESS <u>Queen City Mo.</u>		

(Licensed Embalmer's Statement on Reverse Side)

Date Received: SEP 27 1950  
DISTRICT HEALTH OFFICE #2  
District File Number 9-50-15  
Date Filed: SEP 27 1950

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 .....  
Student Embalmer

Signed \_\_\_\_\_

*Wm H West*

Licensed Embalmer No. \_\_\_\_\_

*2882*

P. O. Address \_\_\_\_\_

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