

FILED DEC 11 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37693
State File No. _____
Registrar's No. 70

BIRTH NO. _____ REG. DIST. NO. 195 PRIMARY REG. DIST. NO. 4308

1. PLACE OF DEATH a. COUNTY <u>Mo. Donald</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Mo. Donald</u>	
b. CITY OR TOWN <u>Noel</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Noel</u> <u>0600</u>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) <u>0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Mamie</u> b. (Middle) <u>Gossman</u> c. (Last) <u>Gossman</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 3-1950</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec 30 1878</u>		9. AGE (In years last birthday) <u>71</u> if UNDER 1 YEAR: Months _____ Days _____ if UNDER 24 HRS.: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>9</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					

13a. FATHER'S NAME <u>Frank Owens</u>		13b. MOTHER'S MAIDEN NAME <u>unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Ed Gossman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME _____ ADDRESS _____	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary thrombosis</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Coronary heart disease</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>4-201</u>	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) _____	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 1947 to Nov 3, 1950, that I last saw the deceased alive on Nov 3, 1950, and that death occurred at 10:45 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>J. D. Mountain J.D.</u>		23b. ADDRESS <u>Noel Mo.</u>		23c. DATE SIGNED <u>Nov 5-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Nov 7-50</u>	24b. DATE _____	24c. NAME OF CEMETERY OR CREMATORY <u>Lee Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Donnetta Ark.</u>		

DATE REC'D BY LOCAL REG. <u>11-6-50</u>	REGISTRAR'S SIGNATURE <u>Maxine Humphreys</u> <u>423</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Edmond Siloan Spigo</u> ADDRESS _____	
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(Licensed Embalmer's Statement on Reverse Side)

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

DIVISION OF HEALTH OF MO.
District No. 5 - Springfield

RECEIVED DEC 6 1950

Dist. File 1250-02471

Date Filed _____

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.

Signed _____
Student Embalmer

Signed W. Platt

Licensed Embalmer No. #29

P. O. Address Sioux Falls, S.D.

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.