

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

5448

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>31 yrs</u>	c. CITY OR TOWN <u>Kansas City</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1249 Denver</u>		f. STREET ADDRESS (If rural, give location) <u>1249 Denver</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u> b. (Middle) _____ c. (Last) <u>GOSOROSKI</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>11/24/54</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>11/8/79</u>	9. AGE (in years last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u>6</u> Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Boss Mfg. Co.</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Lexington, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	

13a. FATHER'S NAME <u>Martin Gosoroski</u>		13b. MOTHER'S MAIDEN NAME <u>No record</u>		14. NAME OF HUSBAND OR WIFE <u>Clara Belle Shanks Gosoroski</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>486-03-9115</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Clara Belle Gosoroski, 1249 Denver</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		DUE TO (b) <u>High Blood Pressure</u>			<u>9 hrs</u>
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					<u>331K</u>

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			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) (Minute)		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 6^{am} 11/24, 1954, to 11/24-4pm, 1954, that I last saw the deceased alive on 11/24, 1954, and that death occurred at 4 P m., from the causes and on the date stated above.

23a. SIGNATURE <u>Arthur L. Pickersell</u> (Degree or title) <u>D.O.</u>		23b. ADDRESS <u>5959 East 13th, K.C. Mo</u>		23c. DATE SIGNED <u>11/26-1954</u>	
--	--	---	--	------------------------------------	--

24a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>11/27/54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>	
--	--	---------------------------	--	--	--	---	--

DATE REC'D BY LOCAL REG. <u>11-26-54</u>		REGISTRAR'S SIGNATURE <u>Neve Minshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John P. Shell, K. C. Mo.</u>	
--	--	--	--	--	--

(Licensed Embalmer's Statement on Reverse Side)

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

FILED DEC 27 1954

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.....
Signature of Student Embalmer

Signed *Thomas A. Sheil*

Licensed Embalmer No. *495*

P. O. Address *X.C. 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.