

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-036387

STATE FILE NUMBER

FILED OCT 23 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4638

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Oak Grove		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hosp			Length of stay in 1b 2 wks	d. STREET ADDRESS (If outside, give location) R.F.D.			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Grover Lee Gosney				4. DATE OF DEATH Month Day Year Oct 1 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 12 1894		9. AGE (In years last birthday) 77 3/4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (City and state or country) Tarsney Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jesse Gosney				14. MOTHER'S MAIDEN NAME Eva Snyder			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 490-30-4897		17. INFORMANT Jessie Gosney		Address KC Mo	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Thrombosis							INTERVAL BETWEEN ONSET AND DEATH 2 Days 2 Days
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Hour . Month, Day, Year a. m. p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from 9-18-58 to 10-1-58 and last saw ^{her} alive on 10-1-58 Death occurred at 5:10 P m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Martin J. Mueller M.D.				22b. ADDRESS 595 Angell Bldg KC Mo		22c. DATE SIGNED 10-2-58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-2-58	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) Blue Springs, Mo.		STATE (State)	
24. FUNERAL DIRECTOR Webb Funeral Home Mo			ADDRESS Blue Springs		25. DATE RECD. BY LOCAL REG. 10-2-58	26. REGISTRAR'S SIGNATURE Neva Minshall	

(Licensed Embalmer's Statement on Reverse Side)

Health,
& Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Martin J. Mueller

OCT 23 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 _____
Signature of Student Embalmer

Signed *William E. Free*

Licensed Embalmer No. *47*

P. O. Address *Chesapeake*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If
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.