

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-040443  
STATE FILE NUMBER

ILLU DEC 2 1958 Registration District No. 155 Primary Registration District No. 3127 Registrar's No. 222

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Oklahoma b. COUNTY Muskogee	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Webb City, Mo.		c. CITY OR TOWN Muskogee, Oklo. 8350 8	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jane Chinn Hosp. 2 Weeks		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) Mrs. Alver Gossett			4. DATE OF DEATH Nov. 24, 1958		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1892	9. AGE (In years less birthday) 66	10. F UNDER 1 YEAR 5 Months 5 Days	11. IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Arkansas	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME James Burnett	13b. MOTHER'S MAIDEN NAME Sarah E. Hampton	14. NAME OF HUSBAND OR WIFE Berther G. Gossett
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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.	17. INFORMANT Mr. B.G. Gossett Address Muskogee, Oklo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sarcinosis of Pelvis</u>		INTERVAL BETWEEN ONSET AND DEATH ?
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____		
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 1

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.) 1992
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from April 4-58 to Nov. 24-58 and last saw her alive on 11-24-58 Death occurred at 4:45 AM on the date stated above; and to the best of my knowledge, from the causes stated.	22a. SIGNATURE M. S. Slawghter (degree or title) D.O. 2	22b. ADDRESS Webb City Mo	22c. DATE SIGNED 11-24-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Nov. 24/58	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.	23d. LOCATION (City, town, or county) (State) Muskogee, Oklo.
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24. FUNERAL DIRECTOR Johnston-Arnice-Simpson Mortuary Webb City, Mo.	25. DATE RECD. BY LOCAL REG. 11-24-58	26. REGISTRAR'S SIGNATURE Mrs. Madeline Switzer
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All diseases in Part I must be causally related.

M.S. SLAWGHTER USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

**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 Harvey E. Amos  
Licensed Embalmer No. 4463  
P. O. Address W.H. City

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.