

Health,
Welfare
Public
Service

FILED FEB 16 1959

IC-20 706 588

SL 18405

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002985
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar No. **1023**

300
1-57
34
38

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N. GRAND, ST. LOUIS, MO.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN JENNINGS 4138 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL		Length of stay in lb 70 days	d. STREET ADDRESS (If outside, give location) 8517 CLIFTON Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First EDWARD Middle J. Last GOSSMAN			4. DATE OF DEATH Month JANUARY Day 28 Year 1959		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/3/98	9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) ST. LOUIS, MO.		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME FERDINAND GOSSMAN		13b. MOTHER'S MAIDEN NAME MARY KUETER		14. NAME OF HUSBAND OR WIFE - - - - -	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or if unknown) (If yes, give war, dates of service) YES WW-2	16. SOCIAL SECURITY NO. 497-03-0456	17. INFORMANT VA HOSP. RECORDS, ST. LOUIS, MO. Address
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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) RECURRENT SQUAMOUS CANCER OF THE LARYNX			INTERVAL BETWEEN ONSET AND DEATH YEARS
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) 161X			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <input type="checkbox"/> NONE <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 checked="" 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 VAH, ST. LOUIS, MO.	COUNTY ST. LOUIS	STATE MO.
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21. I attended the deceased from **11/19/58** to **1/28/59** and last saw **XX** him alive on **1/28/59**
Death occurred at **1:00 A.M.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Murray M. Betts</i> (Degree or title) M.D.	22b. ADDRESS VAH, ST. LOUIS, MO.	22c. DATE SIGNED 1/28/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 1-31-59	23c. NAME OF CEMETERY OR CREMATORY MURRAY M. BETTS, M. D. Memorial Park	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
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24. FUNERAL DIRECTOR Buchholz Mortuary 5967 W. Florissant	25. DATE RECD. BY LOCAL REG. JAN 29 59	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Medical Certification
All diseases in Part I must be causally related.

mfb

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 *Walfrid W. Buchholz*

Licensed Embalmer No. *4557*

P. O. Address *H. Lucas*

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.