

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-020518

STATE FILE NUMBER

FILED JUN 22 1959 42

Primary Registration District No.

613

Registrar's No.

| | | | | | | | | | | | | | |
|--|--|--|--|---|---|--|---|--|--|--|--|----------------|--|
| 1. PLACE OF DEATH a. COUNTY Buchanan | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Wayne Township | | Length of stay in 1b | | c. CITY OR TOWN St. Joseph | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Highway 59 | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 504 No. 11th Street | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) CLIFTON GOSNELL | | | | 4. DATE OF DEATH Month June Day 3 , 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 12/28/97 | | 9. AGE (last birthday) 61 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HR | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (City and state or country) St. Joseph, Missouri | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | | | | |
| 13a. FATHER'S NAME Frank Gosnell | | | | 13b. MOTHER'S MAIDEN NAME Flora Welch | | | | 14. NAME OF HUSBAND OR WIFE none | | | | | |
| 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. none | | 17. INFORMANT Clyde Inman, St. Joseph, 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) Traumatic shock & internal hemorrhage | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH at once | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) Crushed chest, broken left leg | | | | | | | | | | at once | | | |
| DUE TO (c) Struck by Auto while riding bicycle | | | | | | | | | | at once | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT <input checked="" 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.) Victim crossed in front of auto. Both going in the same direction. | | | | | | | | | |
| 20c. TIME OF INJURY 8:30 a.m. | | Hour Month, Day, Year June 3, 1959 | | | | | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway | | 20f. CITY, TOWN, OR LOCATION 3 miles S. of St. Joseph, Buchanan, Mo. | | COUNTY | | STATE | | | | | |
| 21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 8:30 P. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE <i>E. Meluney</i> (Degree or Buchanan) | | | | 22b. ADDRESS 214 Kirkpatrick Bldg St. Joseph, Missouri | | | | 22c. DATE SIGNED 6/5/59 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 6/6/1959 | | 23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery | | | | 23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri | | | | | |
| 24. FUNERAL DIRECTOR <i>John Rupp</i> | | | | ADDRESS St. Joseph, Mo. | | 25. DATE RECD. BY LOCAL REG. June 15, 1959 | | 26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Goodell</i> | | | | | |

DOCUMENT

BY AFFIDAVIT OF E. Meluney, M.D., 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

~~on~~ by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

John E. Rupp

Licensed Embalmer No.

398

P. O. Address

St. Joseph

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.