

**DURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS NOV 17 1959**

**59-040065**

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5197

MEMORIALIZED

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>KANSAS</b> b. COUNTY <b>Wyandotte</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in 1b <b>8 days</b>		c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>VA HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1024 GRANDVIEW BLVD</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>GOSTON</b> Last <b>GOSTON</b>				4. DATE OF DEATH Month <b>October</b> Day <b>27</b> Year <b>1959</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>8-25-95</b>	9. AGE (last birthday) <b>64</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Packing Indust.</b>		11. BIRTHPLACE (City and state or country) <b>Douglassville, Texas</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Charlie Goston</b>			13b. MOTHER'S MAIDEN NAME <b>Evie Whiten</b>			14. NAME OF HUSBAND OR WIFE <b>Lister Goston</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWT</b>			16. SOCIAL SECURITY NO. <b>510 16 1597</b>		17. INFORMANT Address <b>VA Hospital Official Records, K. C. Mo</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain tumor left frontal lobe</b> DUE TO (b) <b>Carcinoma left lung ?</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH	
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 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 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 <b>VA</b> <b>October 19, 1959</b> to <b>October 27, 1959</b> and last saw him arrive on <b>11:22</b> on the date stated above, and to the best of my knowledge, from the causes stated.		Death occurred at _____						
22a. SIGNATURE (Degree or title) <b>A. B. WILLIAMSON, JR., M.D.</b>			22b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b>			22c. DATE SIGNED <b>10-27-59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>10-30-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Fort Leavenworth, Kansas</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Mrs. Meek's Mortuary, K. C. Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>10-29-59</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Marshall</b>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Millard B. Pask

Licensed Embalmer No. 5013

P. O. Address N. C. W.

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.