

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 27yrs.	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 805 Monroe Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First FRANK Middle M. Last GOSOROSKI			4. DATE OF DEATH Month Dec. Day 15, Year 1959		
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-16-1894	9. AGE (last birthday) 65	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Cutter	10b. KIND OF BUSINESS OR INDUSTRY Food	11. BIRTHPLACE (City and state or country) Mayview, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Martin Gosoroski	13b. MOTHER'S MAIDEN NAME Ida Kosmiski	14. NAME OF HUSBAND OR WIFE Margaret M. Gosoroski
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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) Yes WWI	16. SOCIAL SECURITY NO. 495-01-1864	17. INFORMANT Address Mrs. Margaret Gosoroski - 805 Monroe
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary heart failure	1 wk
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	10 days
	myocardial infarction	
	DUE TO (c)	?
	Coronary arteriosclerosis	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Rheumatic mitralis 3 years.	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
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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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year
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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
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21. I attended the deceased from July 19 5-7 to Dec 15, 1959 and last saw her/him alive on Dec 15, 1959
 Death occurred at 6:35 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deceased or title) William F. Sanders MD	22b. ADDRESS 411 Nichols Rd. - Kansas City, Mo	22c. DATE SIGNED 12-16-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12-18-59	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City 33, Mo.
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24. FUNERAL DIRECTOR Melody-McGilley-Eylar	ADDRESS 1800 E. Linwood	25. DATE RECD. BY LOCAL REG. 12-16-59	26. REGISTRAR'S SIGNATURE Neil Minshall
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DOCUMENT

BY AFFIDAVIT OF William F. Sanders - MEDICAL CERTIFICATION

*Dr. Wm. Sanders
411 Nichols
Val-8865
/30-*

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.