

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-015340

FILED VS MAY 16 1960

149

Registration District No. 1002

Registrar's No. 2422

STATE FILE NUMBER

|  |  |   |  |   |  |  |   |  |
|--|--|---|--|---|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>JACKSON County</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> , COUNTY <b>Henry</b> |  |  |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Kansas City</b>  |  | Length of stay in lb <b>106 Days</b>  |  | c. CITY OR TOWN <b>Clinton - Missouri</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St. Luke's</b>   |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   | d. STREET ADDRESS (If outside, give location)<br><b>317 W. Ohio St</b>   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>Laurrine Gosney</b>   |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>April 29 1960</b>  |  |  |   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>       | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>1-5-02</b>   | 9. AGE (last birthday)<br><b>58</b>  | IF UNDER 1 YEAR<br>Months Days   | IF UNDER 24 HR<br>Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>at home</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (City and state or country)<br><b>Henry Co, Mo</b>   |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>  |   |  |
| 13a. FATHER'S NAME<br><b>Walter Masters</b>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Lillie Rainey</b>                                    |   | 14. NAME OF HUSBAND OR WIFE<br><b>JAMES</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>-</b>   |  | 17. INFORMANT<br>Address<br><b>Eugene Masters Calhoun, Mo</b>   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myelogenous Leukemia</b>  |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 months</b>                                  |   |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____   |  |   |  |   |  |  |   |  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> N: <input type="checkbox"/> Unknown |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour a.m. p.m.  | Month, Day, Year                       |   |  |   |  |  |   |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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>Jan. 1958</b> to <b>April 29, 1960</b> and last saw her <b>live</b> on <b>April 29, 1960</b><br>Death occurred at <b>10:15 A.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |   |  |  |   |  |
| 22. SIGNATURE (Degree or title)<br><b>W. H. Slentz, M.D.</b>   |  |   |  | 22b. ADDRESS<br><b>4620 Nichols Pky. K.C. Mo.</b>   |  | 22c. DATE SIGNED<br><b>4-29-60</b>   |   |  |
| 23a. JOURNAL CREMATION, REMOVAL (Specify)  | 23b. DATE<br><b>May 1, 1960</b>        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calhoun Cemetery</b>   |  | 23d. LOCATION (City, town, or county)<br><b>Calhoun, Mo</b>   |  | (State)  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Housey Funeral Home Calhoun, Mo</b>   |  |   | ADDRESS  |   | 25. DATE RECD. BY LOCAL REG.<br><b>5-2-60</b>  | 26. REGISTRAR'S SIGNATURE<br><b>Gene Marshall</b>                                    |   |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed R. L. Dunning

Licensed Embalmer No. 4710

P. O. Address Clinton

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.