

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 19 1960

5909-60-046069 STATE FILE NUMBER

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

DED

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson				
b. CITY (If outside Corporate Limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 16 Years		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 3526 Walnut			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3130 Penn		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN S. GASSMAN				4. DATE OF DEATH Month Day Year 11 23 60				
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 6/3/1890	9. AGE (last birthday) 70 Yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY Self	11. BIRTHPLACE (City and state or country) Munjour, Kansas		12. CITIZEN OF WHAT COUNTRY U.S.		
13a. FATHER'S NAME Joseph Gassman			13b. MOTHER'S MAIDEN NAME Catherine Nieranberger		14. NAME OF HUSBAND OR WIFE			
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. 523-10-2223		17. INFORMANT Address Allen J. Gassman, 646 E 61st Terrace					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema INTERVAL BETWEEN ONSET AND DEATH 12 hrs								
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Ht Dis years								
DUE TO (c) Arteriosclerosis, generalized year								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Ancient cerebrovascular accident						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 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 a.m. p.m. Month, Day, Year								
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 Nov. 1, 1960 to Nov. 23, 1960 and last saw him alive on Nov. 23, 1960 Death occurred at 8:42 A m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) H. Goodson, M.D.				22b. ADDRESS 730 Prof Bldg Kansas City, Mo		22c. DATE SIGNED 11/23/60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/26/60	23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City Mo			
24. FUNERAL DIRECTOR Mellody-McGilley-Eylar Linwood & Main, K.C. Mo.			25. DATE RECD. BY LOCAL REG. 11-24-60		26. REGISTRAR'S SIGNATURE H-L Dwyer			

DOCUMENT

BY AFFIDAVIT OF H. Goodson, M.D.

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed

Wm H. Seitz

Licensed Embalmer No. 5038

P. O. Address K. C. W.

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