

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

8337

PLACE OF DEATH

County Greene Registration District No. 316
 Township Brown Primary Registration District No. 5435
 City _____ (No. _____) St. _____ Ward _____

File No. _____
 Registered No. 11

2. FULL NAME Elgie R. Gouty
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Sarah V. Gouty

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-28-1859

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
80 1 _____

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Retired Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Danville Ind.
 (STATE OR COUNTRY)

PARENTS
 10. NAME OF FATHER Jackson Gouty
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) unknown
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Nemie Knaig
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) unknown
 (STATE OR COUNTRY)

14. INFORMANT Elgie R. Gouty
 (Address) _____

15. FILED 5/5 30 L. Chaston
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 25 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 1930, to March 25, 1930 that I last saw him alive on March 25, 1930, and that death occurred, on the date stated above, at 9:15 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic myo cardial degeneration for 5 years
13
1536 (duration) 5 yrs. mos. ds.

CONTRIBUTORY Chronic nephritis
 (SECONDARY) (duration) 2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
1336
 IS NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) Charles H. McFarlane M. D.
3-26-1930 (Address) Ash Grove, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Ash Grove DATE OF BURIAL 3-26-1930

20. UNDERTAKER Troydon Monroie Leman ADDRESS Ash Grove

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MAY 26 1930

