

No. 2
-2-43
17-39
1 35567

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED DEC 10 1943

Registration District No. 2005

Primary Registration District No. 4492

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Oran
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 12 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Scott

(c) City or town Oran
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John Thurman Gouge

3. (b) If veteran name war Spanish-American (c) Social Security No. 490-24-8772

4. Sex Male 5. Color or face White 6. (a) Single, widowed, married, divorced, Married

6. (b) Name of husband or wife Minnie H Gouge 6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased May 8 1874
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>69</u>	<u>6</u>	<u>1</u>	hr. _____ min.

9. Birthplace Don't Know (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name James Gouge

13. Birthplace Don't Know (City, town, or county) (State or foreign country)

14. Maiden name Sweeney

15. Birthplace Don't Know (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. John Gouge

(b) Address Oran, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 11, 1943 (Month) (Day) (Year)

(c) Place: burial or cremation Marion Mo.

18. (a) Signature of funeral director B. C. Platt (b) Address Chaffee, Mo.

19. (a) 12/8/43 (Date received local registrar) (b) J. P. Dickman (Registrar's signature) Oran Mo

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 9 year 1943 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from Nov 9 1943 to Nov 9 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Angina Pectoris

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature: J. A. Cline (M. D. or other) _____
Address Oran Mo Date signed 11/10/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEC 1 3 1943

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....
Marnie Birplinghoff

Licensed Embalmer No..... *3242*

P. O. Address.....
Chaffee Mo

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 this body is not embalmed, fact should be so stated above.