

FILED AUG 8 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22933

State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>93</u>		PRIMARY REG. DIST. NO. <u>4154</u>		Registrar's No. <u>59</u>	
1. PLACE OF DEATH a. COUNTY <u>Dade</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Dade</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Greenfield</u>		c. LENGTH OF STAY (in this place) <u>4</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Greenfield</u>		d. STREET ADDRESS (If rural, give location) <u>Mitchell Nurcing Home</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mitchell Nurcing Home</u>				d. STREET ADDRESS (If rural, give location) <u>Mitchell Nurcing Home</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u> b. (Middle) <u>Fred</u> c. (Last) <u>Gouty</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 19 1949</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug 29 1862</u>	9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR <u>10</u> Months <u>20</u> Days	IF UNDER 24 HRS. <u>0</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Polk Co Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Thomas Gouty</u>			13b. MOTHER'S MAIDEN NAME <u>Jane Gouty</u>		14. NAME OF HUSBAND OR WIFE <u>Unkown</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Lou Cowan</u> ADDRESS <u>Walnut Grove Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arterio Sclerosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Senility</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>45⁰</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>June 2, 1949</u> to <u>June 10, 1949</u> that I last saw the deceased alive on <u>June 10, 1949</u> , and that death occurred at <u>1:00 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>H. D. Combs</u>				23b. ADDRESS <u>Lockwood Mo</u>		23c. DATE SIGNED <u>7-19-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>July 21, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Ening Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Morrisville Mo</u>	
DATE REC'D BY LOCAL REG. <u>7-21-49</u>		REGISTRAR'S SIGNATURE <u>Les R. Hart</u> <u>79</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W.R. Allison</u> ADDRESS <u>Greenfield Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED JUL 25 1949
District Health Office No. 6,
District File Number 749-849
Date Filed 7-29-49

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.

Signed W. R. Allison
Student Embalmer
Licensed Embalmer No. 4404
P. O. Address Greenfield, 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.