

FILED SEP 21 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30713**

3770

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>3770</u>		
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, write RURAL and give OR TOWN Kansas City <u>4</u> township)		c. LENGTH OF STAY (In this place) 41 Yrs.		c. CITY OR TOWN Kansas City		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <u>3718</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION Lindenman Nursing Home				STREET ADDRESS (If rural, give location) 4503 Belleview				
3. NAME OF DECEASED (Type or Print) ARTHUR		a. (First) _____ b. (Middle) C.		c. (Last) GAULD		4. DATE OF DEATH (Month) (Day) (Year) Aug. 26, 1956		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Oct. 29, 1897		
9. AGE (In years last birthday) 58		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dairy Division, K. C.			10b. KIND OF BUSINESS OR INDUSTRY Health Dept.			11. BIRTHPLACE (City and State or Foreign Country) Abërdeen, Scotland <u>4</u>		
12. CITIZEN OF WHAT COUNTRY? U. S. A.								
13a. FATHER'S NAME William Gauld			13b. MOTHER'S MAIDEN NAME Margaret Pirie			14. NAME OF HUSBAND OR WIFE Myrtle L. Gauld		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W. W. I		16. SOCIAL SECURITY NO. 487-09-5642		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Myrtle L. Gauld Kansas City, Mo.				
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma to Lungs, Cervical & Axillary Nodes. ANTECEDENT CAUSES Renal Carcinoma (Adeno) - Right DUE TO (b) 14 Mos. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS 1. Bronchopneumonia - Lt. Lung. 2) Left Nephrectomy. 3) Left Pneumonectomy.					INTERVAL BETWEEN ONSET AND DEATH 14 Mos. 1908 3 days. 3 Months. 15 months.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 1) Adenocarcinoma Left Kidney. 2) Metastatic Adenocarcinoma Left Lung.					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) (Min.)		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>Jan., 1953</u> , to <u>26 Aug., 1956</u> , that I last saw the deceased alive on <u>26 Aug., 1956</u> , and that death occurred at <u>7:15 P. m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE Phillip G. Kaul (Degree or title) MD				23b. ADDRESS 411 Nichols Road		23c. DATE SIGNED 27 Aug. 56		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8-29-56		24c. NAME OF CEMETERY OR CREMATORY Mt. Moriah		24d. LOCATION (City, town, or county) (State) Kansas City, Mo.		
DATE REC'D BY LOCAL REG. 8-29-56		REGISTRAR'S SIGNATURE Nevas Minshall		25. FUNERAL DIRECTOR'S SIGNATURE Freeman Mortuary		ADDRESS Kansas City, Mo.		

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

The Philip Jones
Room 115
Algebra Time 10:00

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..

Student.....
Signature of Student Embalmer

Signed *Clayton Barnes*

Licensed Embalmer No. *4793*

P. O. Address *R. C., Tenn*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.