

Health, Welfare & Public Services

3007
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED JUN 7 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18712

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4518**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Richmond Hgts.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hosp.		d. STREET ADDRESS (If outside, give location) 7565 Hiawatha Ave.	
3. NAME OF DECEASED (Type or print) First JOHN Middle C. Last GOUTY		4. DATE OF DEATH Month May Day 10th Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		11. BIRTHPLACE (City and state or country) Bois D' Arc, Mo.	
10b. KIND OF BUSINESS OR INDUSTRY Amer. Red Cross		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Gouty		14. MOTHER'S MAIDEN NAME Martha Tatum	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) Yes World War I		16. SOCIAL SECURITY NO. 494-05-6241	
17. INFORMANT Mary E. Gouty		Address 7565 Hiawatha Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease Auricular fibrillation and severe emphysema DUE TO (b) Auricular fibrillation and DUE TO (c) Severe Emphysema PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholecystectomy - Post operative 3 days			INTERVAL BETWEEN ONSET AND DEATH
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.) 420.0	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____		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.) 5-6-57		20f. CITY, TOWN, OR LOCATION COUNTY STATE 5-10-57	
21. I attended the deceased from May 6/57 to May 10/57 and last saw her alive on May 10/57 Death occurred at 11:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Arthur R. Dalton M.D.		22b. ADDRESS 453 N. Taylor	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 13 1957	
23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
24. FUNERAL DIRECTOR A. H. BOCKLAGE		25. DATE RECD. BY LOCAL REG. MAY 13 '57	
ADDRESS 6536 Clayton Rd.		26. REGISTRAR'S SIGNATURE J. Carl Smith MO	

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 *Elmo P. Padwell*

Licensed Embalmer No. *40*

P. O. Address *Sh. So*

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