

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038869

STATE FILE NUMBER

FILED NOV 17 1958

Registration District No. 35 Primary Registration District No. 3006 Registrar's No. 507

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Boone</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>CASS</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Belton</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>UNIVERSITY OF MO. MEDICAL CENTER</u> | | Length of stay in lb <u>4 Days</u> | d. STREET ADDRESS (If outside, give location): <u>0190 711 South Cedar St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET Gochnauer</u> | | | 4. DATE OF DEATH Month Day Year <u>Nov 11 58</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-28-88</u> |
| 9. AGE (In years last birthday) <u>70</u> | | 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) <u>Housekeeper</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | 11. BIRTHPLACE (City and state or country) <u>Belton, Mo.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | 13a. FATHER'S NAME <u>Adam Gochnauer</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Sarah Knox</u> | | 14. NAME OF HUSBAND OR WIFE <u>Alfred Gochnauer</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. ----- | 17. INFORMANT Address <u>UNIVERSITY OF MO. MEDICAL RECORDS</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE RENAL FAILURE SEC. TO</u> DUE TO (b) <u>METASTATIC ADENOCARCINOMA; PRIMARY (GIGANTOCOCOA).</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>1533</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>48 HRS. or less</u> |
| 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.) <u>---</u> | |
| 20c. TIME OF INJURY Hour Month, Day, Year <u>---</u> p.m. | | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, workshop, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>---</u> | |
| 21. I attended the deceased from <u>NOV 57 58</u> to <u>NOV. 10</u> and last saw <u>her</u> alive on <u>NOV. 10. 1958</u> Death occurred <u>1:20 AM NOV 10, 1958</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>Frank A. Mohr, M.D.</u> (Degree & Title) | | 22b. ADDRESS <u>University Med Center; Columbia, Mo.</u> | |
| 22c. DATE SIGNED <u>11/11/58</u> | | 22d. (State) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>11-13-58</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Belton Cemetery</u> | 23d. LOCATION (City, town, or county) <u>Belton, Missouri</u> |
| 24. FUNERAL DIRECTOR <u>Lyman Sprinkle Columbia, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>Nov. 11 1958</u> | 26. REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u> |

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Measurements in centimeters - no symptoms will be listed.

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 *George A. ...*

Licensed Embalmer No. *...*

P. O. Address *...*

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.