

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001314

STATE FILE NUMBER

FILED JAN 21 1959

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 139

|   |                               |   |   |   |   |
|---|-------------------------------|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>   |                               |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u><br>b. COUNTY <u>Jackson</u> |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Kansas City</u>   |                               | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <u>Kansas City</u>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>29th and Freeman</u>  |                               | Length of stay in lb. <u>9 years</u>  | d. STREET ADDRESS <u>3524 Euclid</u>  |   | (If outside) give location<br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <u>HARRY</u> Middle <u>DeLehane</u> Last <u>Gougar</u>   |                               |   | 4. DATE OF DEATH<br>Month <u>JAN.</u> Day <u>7.</u> Year <u>1959</u>  |   |   |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>Cauc.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>April 5, 1874</u>  | 9. AGE (In years last birthday) <u>84</u>                     | IF UNDER 1 YEAR<br>Months _____ Days _____  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired Printer</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Bookbinding</u>   | 11. BIRTHPLACE (City and state or country)<br><u>Marysville, Illinois</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |
| 13a. FATHER'S NAME<br><u>Samuel D. Gougar</u>   |                               | 13b. MOTHER'S MAIDEN NAME<br><u>Charlotte Jacobs</u>  |   | 14. NAME OF HUSBAND OR WIFE<br><u>Della Gougar (deceased)</u> |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u>  |                               | 16. SOCIAL SECURITY NO.<br><u>345-03-9864</u>   | 17. INFORMANT<br><u>MARY BROWN</u> Address <u>3524 Euclid</u>   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>                              |                               |   |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. }<br>DUE TO (b) _____<br>DUE TO (c) _____  |                               |   |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |                               |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</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.)  |   |   |   |
| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m.<br>Month, Day, Year _____   |                               |   |   |   |   |
| 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.)  |   | 20f. CITY, TOWN, OR LOCATION<br>COUNTY _____ STATE _____      |   |
| 21. I attended the deceased from _____ to _____ and last saw her/him alive on _____<br>Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated. |                               |   |   |   |   |
| 22a. SIGNATURE<br><u>Hugh H. Owens</u> (Degree or title)  |                               | 22b. ADDRESS<br><u>1034 Rialto Bldg</u>   |   | 22c. DATE SIGNED<br><u>1-9-59</u>                             |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                               | 23b. DATE<br><u>Jan. 10, 1959</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Moriah Cemetery</u>  |   | 23d. LOCATION (City, town, or county) (State)<br><u>Kansas City Missouri</u>  |
| 24. FUNERAL DIRECTOR<br><u>Muehlebach</u>   |                               | ADDRESS<br><u>6800 TROST</u>  |   | 25. DATE RECD. BY LOCAL REG.<br><u>1-9-59</u>                 | 26. REGISTRAR'S SIGNATURE<br><u>Merle Marshall</u>  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Hugh H. Owens

*Carbon Copy*

**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 *P. I. Nichols* .....

Licensed Embalmer No. .... *4997* ..

P. O. Address ..... *K. C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.**

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