

No. 300
-10-47
5-17-39
I 3905

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **25959**
Registrar's No. **684**

FILED AUG 23 1948
Registration District No. **28**

Primary Registration District No. **2000**

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

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
O'Reilly Veterans Administration Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 Mo. 3 days
(Specify whether years, months or days)

In this community 27 Years

3. (a) PRINT FULL NAME Charles E. Gold

3. (b) If veteran, name war WW I

3. (c) Social Security No. 702 16 5641

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Sarah Gold

6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased July 4 1889
(Month) (Day) (Year)

8. AGE: Years 59 Months 1 Days 12 If less than one day
hr. min.

9. Birthplace Stone Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Unknown

11. Industry or business

12. Name John Gold

13. Birthplace Stone Co. Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Martha Jackson

15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records

(b) Address O'Reilly VAH Springfield, Mo.

17. (a) Interment (b) Date thereof 8-17-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crane Mo.

18. (a) Signature of funeral director [Signature]

(b) Address Springfield Mo.

19. (a) 9-18-48 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stone **104**

(c) City or town Crane **1**
(If outside city or town limits, write "RURAL")

(d) Street No. None **0**
(If rural, give location)

(e) Citizen of foreign country? No **1**
(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 16
year 1948 hour 7 minute 15 P.M.

21. I hereby certify that I attended the deceased from November 13 1947 to August 16 1948,
that I last saw him alive on August 16 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis Pulmonary, Chronic, Far Advanced, Active.

Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations 1313

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place) Without work (e) Means of injury [check]

23. Signature [Signature] (M. D. or other) **0**

Address PAUL H. EISELE, M.D., O'Reilly VAH Spfld., Mo. Date signed 8/16/48

SEP 14 1948

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 _____
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed Lewis G. Schopf
Licensed Embalmer No. 3810 2
P. O. Address Springfield, 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.