

FILED MAR 19 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7571

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 281

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	c. LENGTH OF STAY (In this place) 4 days	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural; Center Township 0110	
d. FULL NAME OF HOSPITAL OR INSTITUTION 211 Texas Avenue Silvey Rest Home		d. STREET ADDRESS (If rural, give location) 3 1/2 mi. S. on highway #71	

3. NAME OF DECEASED (Type or Print)	a. (First) Laura	b. (Middle) Eva	c. (Last) Gaunt	4. DATE OF DEATH (Month) (Day) (Year) March 9 1951
-------------------------------------	------------------	-----------------	-----------------	--

5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2	8. DATE OF BIRTH Nov. 26, 1872	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	Min.
---------------	------------------------	--	--------------------------------	------------------------------------	------------------------	------------------------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
---	--	--	----------------------------------

13a. FATHER'S NAME G. W. Ogden	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE James A. Gaunt
--------------------------------	-----------------------------------	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) _____	17. INFORMANT'S SIGNATURE OR NAME Mrs. Myrtle Bryant, R.F.D. #5, St. Joseph, Mo.	ADDRESS
--	--	--	---------

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocardial Insufficiency		Unknown
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio Sclerosis General DUE TO (c) Diabetes Mellitus		Unknown
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			Unknown

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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) m.	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 January 7, 1951, to March 9, 1951, that I last saw the deceased alive on March 9, 1951, and that death occurred at 8:00 P.M., from the causes and on the date stated above.

23a. SIGNATURE Justin A. Rau	(Degree or title) 0	23b. ADDRESS M. S. Kirkpatrick Bldg. St. Joseph, Mo.	23c. DATE SIGNED 3-10-51
------------------------------	---------------------	--	--------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3/12/51	24c. NAME OF CEMETERY OR CREMATORY Westlawn Cemetery	24d. LOCATION (City, town, or county) (State) DeKalb Missouri
--	-------------------	--	---

DATE REC'D BY LOCAL REG. 3-13-51	REGISTRAR'S SIGNATURE Carl C. Carter	446	25. FUNERAL DIRECTOR'S SIGNATURE Heaton-Bowman Funeral Home	ADDRESS St. Joseph, Mo.
----------------------------------	--------------------------------------	-----	---	-------------------------

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

117
4

Dr. H. A. Parsons

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.

Signed _____

James P. Hawkins

Signed _____
Student Embalmer

Licensed Embalmer No. 4536

P. O. Address 319 E. 10th St. Jones

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.