

FILED OCT 8 1951

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29975
Registrar's No. 846

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield	
c. LENGTH OF STAY (in this place) 33 yrs		d. STREET ADDRESS (If rural, give location) 1029 S Broadway	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1029 S Broadway			

3. NAME OF DECEASED (Type or Print) a. (First) MAUDE b. (Middle) N. c. (Last) GAULT			4. DATE OF DEATH (Month) (Day) (Year) Oct 3 1951		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	
8. DATE OF BIRTH Jan 12, 1890		9. AGE (In years last birthday) 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse	
10b. KIND OF BUSINESS OR INDUSTRY Private Duty		11. BIRTHPLACE (State or foreign country) Greene Co., Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Jacob C Gault		13b. MOTHER'S MAIDEN NAME Louise Graves		14. NAME OF HUSBAND OR WIFE ---	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Jacob Gault, Springfield, Missouri	

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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis, generalized ANTECEDENT CAUSES Primary source left breast DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>			INTERVAL BETWEEN ONSET AND DEATH 1 yr.
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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) 170X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 Sept 15, 1951, to Oct 3, 1951, that I last saw the deceased alive on Sept 28, 1951, and that death occurred at 9:17 p.m., from the causes and on the date stated above.

23a. SIGNATURE K. Wendell Stewart (Degree or title) M.D.		23b. ADDRESS 203 Professional Bldg Springfield, Mo.		23c. DATE SIGNED Oct 5, 51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Oct 6, 1951		24c. NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State) Eastlawn Cemetery Springfield, Mo.	

DATE REC'D BY LOCAL REG. 10-5-51		REGISTRAR'S SIGNATURE W.B. Handley		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Alma Schmaper, Springfield, Mo.	
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(Licensed Embalmer's Statement on Reverse Side)

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

396

Stewart
Pres. B6

MAY 8 1958

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed Bernard F. Wright

Signed.....
Student Embalmer

Licensed Embalmer No. 4293

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.