

FILED JUN 26 1952

THE REPUBLIC OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21035**

BIRTH NO. _____ REG. DIST. NO. **174** PRIMARY REG. DIST. NO. **3035** Registrar's No. **51**

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

1. PLACE OF DEATH a. COUNTY Lafayette		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Ray	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lexington		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Orriok, 0890	
c. LENGTH OF STAY (In this place) 13 Hours		d. STREET ADDRESS (If rural, give location) South 1071	
d. FULL NAME OF HOSPITAL OR INSTITUTION Memorial Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Ora b. (Middle) A. c. (Last) Gott			4. DATE OF DEATH (Month) (Day) (Year) June-6-53 1952		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH: June 17, 1882	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR: Months 11 Days 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Henrietta, Mo.		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Joseph T. Sallee	13b. MOTHER'S MAIDEN NAME Jennie Crawford	14. NAME OF HUSBAND OR WIFE David Carey Gott
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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. None	17. INFORMANT'S SIGNATURE OR NAME David C. Gott	ADDRESS Orriok, Mo.
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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 12 hrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) -- DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4201	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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
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22. I hereby certify that I attended the deceased from **June 6, 1952**, to _____, 19____, that I last saw the deceased **5:30 PM on 6/6/52**, and that death occurred at **6:20 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE Ben H. Brasher MD (Degree or title)	23b. ADDRESS Lexington, Missouri	23c. DATE SIGNED 6/10/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-10-52	24c. NAME OF CEMETERY OR CREMATORY Half Way Cemetery	24d. LOCATION (City, town, or county) (State) Halfway, Mo.
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DATE REC'D BY LOCAL REG. 6-8-52	REGISTRAR'S SIGNATURE Manuel Sustabek	25. FUNERAL DIRECTOR'S SIGNATURE B. W. Good	ADDRESS Orriok, Mo
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MAY 26 1988

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.....
Student Embalmer

Signed.....

John Pauley

Licensed Embalmer No. 4308

P. O. Address Liberty, 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.