

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED FEB 24 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 84

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Miller</u>	
b. CITY OR TOWN <u>Fulton</u>	c. LENGTH OF STAY (in this place) <u>12d</u>	c. CITY OR TOWN <u>Eldon</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION. <u>State Hosp #1</u>		e. STREET ADDRESS (If rural, give location) <u>AURORA-SPRINGS-</u>	

3. NAME OF DECEASED (Type or Print) <u>ARIXONA</u>	a. (First)	b. (Middle)	c. (Last) <u>GOUGE</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 19 1953</u>
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5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M</u>	8. DATE OF BIRTH <u>Aug 11-1866</u>	9. AGE (In years last birthday) (Months) (Days) <u>86 6 3</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>work</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Mo O</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>dk</u>	13b. MOTHER'S MAIDEN NAME <u>dk</u>	14. NAME OF HUSBAND OR WIFE <u>Albert Souge</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>dk</u>	16. SOCIAL SECURITY NO. <u>dk</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Albert Souge</u>	ADDRESS <u>Eldon Mo R</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chr myocarditis</u>	DUPLICATE TO (b) _____		
ANTECEDENT CAUSES	DUPLICATE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senile psychoses simple type</u>			

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>None</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>L</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>None</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>None</u>
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22. I hereby certify that I attended the deceased from 8-7, 1953, to 2-19, 1953, that I last saw the deceased alive on 2-19, 1953 and that death occurred at 1:52 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>J Caldwell M.D.</u>	23b. ADDRESS <u>State Hosp Fulton Mo</u>	23c. DATE SIGNED <u>2-19-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>22 Feb 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Dooley-</u>	24d. LOCATION (City, town, or county) (State) <u>MILLER-CO- MO</u>
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DATE REC'D BY LOCAL REG. <u>Feb 19-1953</u>	REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Keith McKay</u>	ADDRESS <u>ELDON MO</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0143

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, ~~\_\_\_\_\_~~....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Keith M. Keys*.....  
Licensed Embalmer No. *3998*  
P. O. Address *Edon*.....

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.