

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1955

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 140

1. PLACE OF DEATH a. COUNTY <u>St Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution). a. STATE <u>Missouri</u> b. COUNTY <u>St Charles</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Charles</u>	c. LENGTH OF STAY (In this place) <u>40 yrs</u>	c. CITY OR TOWN <u>St Charles</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Joseph Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>125 Houston</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Virginia</u>	b. (Middle) <u>F</u>	c. (Last) <u>Gauss</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>June 26 1955</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 28 1883</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House keeper</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>San Antonio Texas</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Charles H. Gauss</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Gauss</u>	14. NAME OF HUSBAND OR WIFE <u>-----</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mary G. Gauss</u>	ADDRESS <u>St Charles Mo</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial infarction.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u>
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b) <u>Gen arterio Sclerosis.</u>		<u>5 yrs</u>
DUE TO (c) <u>4201</u>	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Congestive Heart Failure</u>		<u>1 yr.</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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 12-28-1955, to 6-26-1955, that I last saw the deceased alive on 6-26-1955, and that death occurred at 2 P m., from the causes and on the date stated above.

23a. SIGNATURE <u>Rif Kinder MD</u>	(Degree or title)	23b. ADDRESS <u>St Charles Mo</u>	23c. DATE SIGNED <u>June 30 1955</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>June 29 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St Charles Mo.</u>
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DATE REC'D BY LOCAL REG <u>June 30 1955</u>	REGISTRAR'S SIGNATURE <u>James Howard Thomas</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>James Howard Thomas</u>	ADDRESS <u>St Charles</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

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**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.

Student.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.