

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-028269

STATE FILE NUMBER

933

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 933

**FILED SEP 8 1958**

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		c. CITY OR TOWN <u>St. Joseph</u>	
c. FULL NAME OF (If not at home, give location) HOSPITAL OR INSTITUTION <u>No. W. Mo. Nurs. He.</u>		d. STREET ADDRESS (If outside, give location) <u>1718 South 6th St.</u>	
Length of stay in lb <u>50 Years</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Onie</u> Middle <u></u> Last <u>Gault</u>		4. DATE OF DEATH Month <u>August</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 18, 1885</u>
9. AGE (In years last birthday) <u>72</u>		IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Richmond, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Ruben Bell</u>	
13b. MOTHER'S MAIDEN NAME <u>Martha Beshears</u>		14. NAME OF HUSBAND OR WIFE <u>Albert Gault</u>	
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 Address <u>Roy Lewis, 107 Felix Street, City</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Unk.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<u>4500</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>St. Joseph Buchanan Mo</u>	
21. I attended the deceased from _____ to _____ and last saw her <sup>her</sup> <sub>alive</sub> on _____		21. CITY, TOWN, OR LOCATION COUNTY STATE <u>St. Joseph Buchanan Mo</u>	
Death occurred at _____ a. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>S. E. McInerney M.D. Coroner</u>		22b. ADDRESS <u>Social Welfare Board 10th &amp; Olive, St. Joseph, Mo.</u>	
22c. DATE SIGNED <u>8/29/58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Aug. 30, 1958</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ashland Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>	
24. FUNERAL DIRECTOR <u>Wm. H. Alexander</u>		25. DATE RECD. BY LOCAL REG. <u>Aug 28, 1958</u>	
ADDRESS <u>St. Joseph, Mo.</u>		26. REGISTRAR'S SIGNATURE <u>Mr. Clark Gardell</u>	

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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Dr. S. E. McInerney

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 ..... *Wm. H. Alexander*

Licensed Embalmer No. *4450*.....

P. O. Address *St. Joseph*.....

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.