

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-033181

STATE FILE NUMBER

FILED OCT 15 1958

Registration District No. 150 Primary Registration District No. 4241 Registrar's No. 210

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Oak Grove</u>		c. CITY OR TOWN <u>Lone Jack 700⁶⁰</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>At Home - City</u>		d. STREET ADDRESS (If outside, give location) <u>Lone Jack, Missouri</u>	
Length of stay in lb <u>60 days</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>William</u> Last <u>Gudde</u>			4. DATE OF DEATH Month <u>October</u> Day <u>2</u> Year <u>1958</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 14, 1882</u>
9. AGE (In years last birthday) <u>76</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>18</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>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>	11. BIRTHPLACE (City and state or country) <u>Holden, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Bernard Gudde</u>	
13b. MOTHER'S MAIDEN NAME <u>Adeline Belman</u>		14. NAME OF HUSBAND OR WIFE <u>Elizabeth O'Brien Gudde</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>XXXXXX</u>	17. INFORMANT Address <u>Virginia Corn, Lee's Summit, Missouri</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>Cerebral Hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>16 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>331X</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arterio Sclerotic Heart Disease</u>			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.) <u>2</u>		
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u></u>		20f. CITY, TOWN, OR LOCATION <u></u>	COUNTY <u></u> STATE <u></u>
21. I attended the deceased from <u>1952</u> to <u>10-2-1958</u> and last saw ^{him} alive on <u>10-2-1958</u> Death occurred at <u>11 P M</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>J. J. J. J.</u>		22b. ADDRESS <u>110 Oak Grove, Mo</u>	22c. DATE SIGNED <u>10/3/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>Oct 4, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Holden, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Canada & Ropp, Holden, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>10-8-1958</u>	26. REGISTRAR'S SIGNATURE <u>M. B. Longford</u>

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *W. J. Canaday* _____

Licensed Embalmer No. 3434 _____

P. O. Address.. Holden, Missouri

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.