

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024890

FILED VS. AUG 10 1959 37

Primary Registration District No. 3023 Registrar's No. 180

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Henry</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clinton</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Clinton General Hosp</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Henry</u> c. CITY OR TOWN <u>Clinton</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Rte 5</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
3. NAME OF DECEASED First Middle Last <u>Grover C. Gaugh.</u>				4. DATE OF DEATH Month Day Year <u>July 27, 1959</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 12, 1897</u>		9. AGE (last birthday) <u>71</u> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HR: _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Operator Selling Station and Motel</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Kansas City, Mo.</u>				11. BIRTHPLACE (City and state or country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>William Gaugh</u>				13b. MOTHER'S MAIDEN NAME <u>Maggie Walters</u>				14. NAME OF HUSBAND OR WIFE <u>Kathryn Gaugh</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>495-24-4700</u>				17. INFORMANT <u>Mrs Grover Gaugh</u> Address <u>Clinton, Mo.</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>Ruptured Abdominal Aneurysm</u> DUE TO (b) <u>Arteriosclerotic Vascular Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown											
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. Month, Day, Year _____		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.) _____		20f. CITY, TOWN, OR LOCATION _____		COUNTY _____		STATE _____					
21. I attended the deceased from <u>27 July 1959</u> to <u>27 July 1959</u> last saw her alive on <u>27 July 1959</u> Death occurred at <u>5:10 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Do not write title) <u>J.M. Intyre M.D.</u>				22b. ADDRESS <u>Clinton, Mo.</u>				22c. DATE SIGNED <u>27 July 59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>JULY 27-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>D.W. NEWSOMERS SONS</u>		23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MO.</u>					
24. FUNERAL DIRECTOR ADDRESS <u>D.W. Newsomers Sons H.C. Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>July 27-59</u>		26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>					

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 31 1956

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

James W. Peterson

Licensed Embalmer No. 4889

P. O. Address

A.C. 7/1

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.