

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30268**
3930

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jacmson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION Research Hospital		d. STREET ADDRESS (If rural, give location) 1323 E 9th	

3. NAME OF DECEASED (Type or Print) a. (First) Dora	b. (Middle) L.	c. (Last) Gauert	4. DATE OF DEATH (Month) (Day) (Year) 9/11/49
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5. SEX Fem	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Wid.	8. DATE OF BIRTH 1/31/1878	9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Days	IF UNDER 15 MINS. Hours	IF UNDER 15 MINS. Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Germany	12. CITIZEN OF WHAT COUNTRY? US
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13a. FATHER'S NAME Johannas	13b. MOTHER'S MAIDEN NAME Unk	14. NAME OF HUSBAND OR WIFE Henry W. Gauert
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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) no	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME Louis A. Gauert	ADDRESS 5001 E 9th K. C. Mo
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 18 hours
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage -		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis and DUE TO (c) hypertension		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION 331x	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) none	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) (Minute)	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 **9-11, 1949**, to **9-11, 1949**, that I last saw the deceased alive on **9-11, 1949**, and that death occurred at **11:15 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE G. M. Osgood	23b. ADDRESS 915 Professional Bldg	23c. DATE SIGNED 9-13-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/14/49	24c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery	24d. LOCATION (City, town, or county) (State) Kansas City, Mo.
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DATE REC'D BY LOCAL REG. 9-13-49	REGISTRAR'S SIGNATURE Staldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE John P. Sheil	ADDRESS Kansas City, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Osgood
Professional Bldg.,
After 2.30

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed.....

John P. Steel

Licensed Embalmer No. 3625

P. O. Address 667th

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 this body is not embalmed, fact should be so stated above.