

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

3676

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis Mo.** (No. **2416 - N 22 - St**)

File No. **274**

Registered No. **274**

2. FULL NAME

Annabelle Guthrie

(a) Residence. No. **2416 - N 22 - St.** **20** Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Single**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **June 5 - 1917**

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
11 7 -

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **School Girl**
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Iowa**
(STATE OR COUNTRY)

10. NAME OF FATHER **James H. Guthrie**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Iowa**
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Currie abemath**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Iowa**
(STATE OR COUNTRY)

14. INFORMANT **James Guthrie**
(Address) **2416 - N 22 - St.**

15. FILED **Jan - 7 1929** REGISTRAR **Max C. Farley**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Jan 5 1929**

17. I HEREBY CERTIFY, That I attended deceased from **Jan 3 1929**, to **Jan 5 1929**, that I last saw him alive on **Jan 5 1929**, and that death occurred, on the date stated above, at **10:45 PM** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia

CONTRIBUTORY (SECONDARY) **10/10** (duration) yrs. mos. ds. **3**

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **W.E. Bruner** M. D.

Jan 6 1929 (Address) **4064 Olive**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Belle Mo.** DATE OF BURIAL **Jan 8 1929**

20. UNDERTAKER **26 1/2 Leidner and Co. N. Market St.**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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