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

Do not use this space.

34865

File No. 77

Registered No.

1. PLACE OF DEATH

County St. Francois

Township St. Francois

City Flat River - Mo. (No. ..... St. ..... Ward)

Registration District No. 7748B

Primary Registration District No. 6048B

2. FULL NAME Frank Guitard

(a) Residence. No. ..... St., ... 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	married.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 7 - 1874.

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
55	yrs.	10 mos	6 days	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) Hasbat worked for 10 yrs.

(c) Name of employer none.

9. BIRTHPLACE (CITY OR TOWN) Fredricktown, Mo.
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Frank Guitard.

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

12. MAIDEN NAME OF MOTHER Anne Huber.

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

14. INFORMANT Anna Guitard
(Address) Flat River.

15. FILED Oct 28 1929 W J Bryan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 13 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1929, to Oct 13, 1929 that I last saw him alive on Oct 13, 1929, and that death occurred, on the date stated above, at 1 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza

87 B

11 P. (duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (SECONDARY) Apoplexy

(duration) ..... yrs. 6 mos. — ds.

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) E C Rohrbach MD M.D.

10/14, 1929 (Address) Flat River Mo

*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	DATE OF BURIAL
I.O.O.F. Cemetery - Fredricktown	Oct 15 1929
20. UNDERTAKER	ADDRESS
Caldwell Bros & Hood - per Alvin Hood	Flat River

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County St Francois Registration District No. 774 File No. 77
Township ..... Primary Registration District No. 6018 B Registered No. .....
City Flat River (No. ....., ... St. ..... Ward).

2. FULL NAME Frank Guifford

(a) Residence. No. ..... St., ... 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 7 1874

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
X	55	10	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

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

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. Oct 28 19 29 W J Bryan
FILED ....., 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 13 1929

17. I HEREBY CERTIFY, That I attended deceased from .....
..... 19..... to ....., 19.....
that I last saw h..... alive on ....., 19....., and that
death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
..... (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY .....
(SECONDARY)
..... (duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D.
, 19 (Address)

*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	DATE OF BURIAL
	19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

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 it may be properly classified. Exact statement of OCCUPATION is very important.
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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