

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City..... *St Louis*

Registration District No. *791*
Primary Registration District No. *1003*
(No. *4941*, *Beacon a*)

File No. *36127*
Registered No. *10652*
St. Ward)

2. FULL NAME

(a) Residence. No. St. *7* 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 <i>male</i>	4. COLOR OR RACE <i>white</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>single</i>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF			
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Oct 19th 1931</i>			
7. AGE	YEARS	MONTHS	DAYS
			<i>0</i>
8. OCCUPATION OF DECEASED			
(a) Trade, profession, or particular kind of work <i>None</i>			
(b) General nature of industry, business, or establishment in which employed (or employer)			
(c) Name of employer			

9. BIRTHPLACE (CITY OR TOWN) *St Louis Mo*
(STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <i>Arthur Guntly</i>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <i>St Louis</i>
	12. MAIDEN NAME OF MOTHER <i>Edith Blodgett</i>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Iowa</i>

14. INFORMANT *Arthur Guntly*
(Address) *4941 Beacon a*

15. FILED *Oct 20 1931*
19 *Max G Starkloff*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *10-19-1931*
17. I HEREBY CERTIFY, That I attended deceased from *10-19-1931* to *10-19-1931* that I last saw him alive on *10-19-31*, 1931, and that death occurred, on the date stated above, at *7:30 a. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral edema 160B
160B
(duration) yrs. mos. ds.
CONTRIBUTORY *Ticeps Delivery*
(SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.
DID AN OPERATION PRECEDE DEATH? *no* DATE OF
WAS THERE AN AUTOPSY? *no*
WHAT TEST CONFIRMED DIAGNOSIS *Physical signs*
(Signed) *H. Miller*, M. D.
10/20, 1931 (Address) *8410 N. Broadway*

*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 *Calvary* DATE OF BURIAL *10-20 1931*
20. UNDERTAKER *Arthur J. Donnelly Undr* ADDRESS *2039 North St*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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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