

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003State File No. **16577**
Registrar's No. **4055**Registration District No. **791**

Primary Registration District No. _____

1. PLACE OF DEATH:

- (a) County _____
 (b) City or town **St. Louis**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **In route to hospital** **3**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME **Richard W. Guthrie** **360**3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **single**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **March 22, 1940.**
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
0 1 13 hr. min.9. Birthplace **St. Louis, Mo.**
(City, town, or county) (State or foreign country)10. Usual occupation **Nil.**

11. Industry or business _____

12. Name **Charles W. Guthrie**13. Birthplace **Missouri**
(City, town, or county) (State or foreign country)14. Maiden name **Viola Hannangen**
15. Birthplace **Illinois**
(City, town, or county) (State or foreign country)16. (a) Informant's own signature **Charles W. Guthrie**(b) Address **4441 Laclede Ave.,**17. (a) **Burial** (b) Date thereof **May 7/40.**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Valhalla Cem.,**(a) Signature of funeral director **Jos. W. Clark**(b) Address **1125 Hodiamont Ave.,**19. (a) **MAY 9 1940** (b) _____
(Date received local registrar) (Signature of registrar)

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Mo.** (b) County _____
 (c) City or town **St. Louis** **19**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **4441 Laclede Ave.,**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **4**
year **1940** hour **10.30** minute **A.M.**21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.Immediate cause of death **Pulmonary Atelectases,
Enlarged Thymus; Atresia of Colon.**Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)Major findings: _____
Of operations _____
Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(c) Means of injury _____23. Signature **Edith J. Perry** (M. D. or other) _____
Address **2125 Hodiamont Ave.** Date signed **5.6.40**

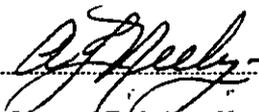
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....


..... Licensed Embalmer No. **3225**.....

P. O. Address **1125 Hodiament Ave.,**

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, above space should be left blank.