

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

39525
Do not use this space.

1. PLACE OF DEATH *701 DEC 1940*

(a) County *Woollooney* Registration District No. *701*

(b) Township *Woollooney* Primary Registration District No. *442* Registered No. _____

(c) City *Monniskville* Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____

(e) Length of residence in city or town where death occurred *30* yrs. mos. ds. (f) *How long in U.S., if of foreign birth* *83* yrs. mos. ds.

2. PRINT FULL NAME *ABSALOM Guthrie*

(a) Residence, No. *Monniskville Mo 0* St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *MALE* 4. COLOR OR RACE *WHITE* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *MARRIED*

5A. MARRIED, WIDOWED, DIVORCED HUSBAND OF (OR) WIFE OF *Charity Guthrie*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *April 15 - 1855*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
85 7 1

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Farmer*

9. Industry or business in which work was done, as saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Dallas Co. Mo.*

FATHER 13. NAME *Timothy Guthrie*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*

MOTHER 15. MAIDEN NAME *Emily Butcher*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*

17. INFORMANT (ADDRESS) *Charity Guthrie Monniskville Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Monniskville* DATE *11-18 40*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *White, Loring & Co. - Monniskville*

20. FILED *11/17 1940* *Wm. J. Vance* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Nov - 16 - 1940*

22. I HEREBY CERTIFY, That I attended deceased from *June 28, 1938* to *Nov - 16 - 1940*

I first saw *him* alive on *Nov - 16 - 1940*. Death is said to have occurred on the date stated above, at *4 P. M.*

The principal cause of death and related causes of importance were as follows:

Chronic Prostatitis

Chronic Bronchitis

Other contributory causes of importance: *1961*

Name of operation _____ Date of _____

What test confirmed diagnosis? *Diagnosed as there an autopsy was*

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? *no*
If so, specify _____

(Signed) *W. J. Vance* M. D.
(Address) *Monniskville Mo.*

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.

RECEIVED

District Health Officer No. 7,

District File Number 12-40-1603

Date Filed 12-2-40

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.....

Personally

....., Registered Apprentice No.

working under my personal supervision.

Signed

William B. Erwin

Licensed Embalmer No.

3092

P. O. Address

Galena Mo.

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.