

No. 2
5-42
5-17-39
X32531

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13716

State File No. _____

ED MAY 3 1943 42

Registration District No. _____

Primary Registration District No. 1000

Registrar's No. 446

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town Saint Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Rosary Hill Nursing Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 month
(Specify whether years, months or days)

In this community Unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Buchanan

(c) City or town Saint Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. 108 North 2nd. Street
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Edgar B. Guthridge

3. (b) If veteran, name war Unknown

3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased June 2nd 1867
(Month) (Day) (Year)

8. AGE: Years 75 Months 10 Days 5 If less than one day _____ hr. _____ min.

9. Birthplace New Florence, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Painter

11. Industry or business House

12. Name Unknown

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Social Welfare Records

(b) Address 904 So. 10th. Street

17. (a) burial (b) Date thereof 4/13/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director [Signature]

(b) Address 319 So. 10th. Street, Home

19. (a) 4-13-43 (b) Rose Skizog
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7th year 1943 hour 10:00 minute 20 p. a. M.

21. I hereby certify that I attended the deceased from april - 1 1943 to april 7 1943
that I last saw him alive on april 6 1943
and that death occurred on the date and hour stated above.

Immediate cause of death nutritional insufficiency Duration 6 yrs

Due to arteriosclerosis

Due to _____

Other conditions (include pregnancy within 3 months of death) 92 h

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) (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address 805 Draper St Date signed 4-8-43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 4/7/43, Registered Apprentice No. ✓
working under my personal supervision.

Signed Harold Rowman

Licensed Embalmer No. 3619

P. O. Address St. Joseph, M

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, fact should be so stated above.