

U. S. No. 2  
OM-9-4-41  
Rev. 5-17-39

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 27378  
Registrar's No. 259

FILED SEP 12 1944

Registration District No. 47

Primary Registration District No. 3008

14  
1  
2

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

1. PLACE OF DEATH

(a) County Callaway

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

(c) Name of hospital or institution: State Hospital No. 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 m 2 1/2 days  
(Specify whether

In this community Yes  
years, months or days)

3. (a) PRINT FULL NAME George H. Guebbes

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Male

5. Color of race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Carrie Guebbes

6. (c) Age of husband or wife if alive 76 years 1865

7. Birth date of deceased: Mar (Month) 6 (Day) 1865 (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>5</u>	<u>6</u>	hr. _____ min. _____

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Guebbes

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

14. Maiden name H.

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

16. (a) Informant Record

(b) Address \_\_\_\_\_

17. (a) Burial (b) Date thereof 8/14-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centralia Mo. Home

18. (a) Signature of funeral director George H. Guebbes

(b) Address Centralia Mo.

19. (a) 8/14-1944 (b) George H. Guebbes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone

(c) City or town Centralia  
(If outside city or town limits, write "RURAL") 2

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 12  
year 1944 hour 10-20 minute 0 M.

21. I hereby certify that I attended the deceased from 8-6-44 to 8-12-44  
that I last saw him alive on 8-12-44  
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia

Due to Arteriosclerosis

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: 108

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_

Signature George H. Guebbes (M. D. or other) MA

Address Fulton Mo. Date signed 8/12/44

MOTHER FATHER

PHYSICIAN  
Underline the cause to which death should be charged statistically.

1147

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 9-9-44

**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 W. M. Housard

Licensed Embalmer No. 4313

P. O. Address Centralia 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, fact should be so stated above.**