S. No. 2
M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 12 1944

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

37333

State File No.

Registration District No. 47

Primary Registration District No. 5161

Registrar's No. 390

**1. PLACE OF DEATH:**

(a) County Callaway

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

(c) Name of hospital or institution:
NewBloomfield, Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution No 1 (Specify whether
In this community Life
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Callaway 14

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

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

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Leslie Chalfant Guthrie

3. (b) If veteran, name war No

3. (c) Social Security No. No

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 10 (Month) 2 (Day) 1888 (Year)

8. AGE: Years 56 Months 1 Days 22 If less than one day hr. min.

9. Birthplace Callaway Co. (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Farmer & Merchant

11. Industry or business Farrming

FATHER
12. Name James S. Guthrie
13. Birthplace Callaway Co. (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Laura Murray
15. Birthplace CallawayCo. (City, town, or county) Missouri (State or foreign country)

16. (a) Informant G. P. Sanders
(b) Address NewBloomfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/1944 (Month) (Day) (Year)
(c) Place: burial or cremation NewBloomfield, Mo.

18. (a) Signature of funeral director Ray A. Holt
(b) Address NewBloomfield, Mo.

19. (a) 11-26-1944 (Date received local registrar) (b) Josie Morsund Lieff (Registrar's signature)

N 47

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 11 day 24 year 1944 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from Nov 13, 1944 to Nov 24, 1944 that I last saw him alive on Nov 24, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Endocarditis - Pericarditis

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

92

Duration

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature E. McD Reed (M. D. or other)

Address New Bloomfield Mo Date signed 11/26/44

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9

District File Number _____

Date Filed 12-11-44

**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 Ray A. Holt

Licensed Embalmer No. 2605

P. O. Address New Bloomfield Pa.

**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.**