

V. S. No. 2
 FORM-5-43
 Rev. 5-17-39
 I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 11293
4047
 Registrar's No. _____

FILED MAY 12 1945
 Registration District No. 318

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution:
5351 West Avenue
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town city of St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 5351 West Avenue
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 0
 If yes, name country _____

3. (a) PRINT FULL NAME Rose Ann Guthridge

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex female 5. Color or race white

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: January ? 1870
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5th
 year 1945 hour 7:10 minute 0 P.M.

21. I hereby certify that I attended the deceased from May 1,
1945, to May 5, 1945;
 that I last saw her alive on May 3d, 1945;
 and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Infarction Duration 7 days

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>5</u>	<u>?</u>	_____ hr. _____ min.

Due to Arteriosclerosis, angina 2 years

9. Birthplace: St. Louis Missouri
(City, town, or county) (State or foreign country)

Due to _____

10. Usual occupation housework

Other conditions: _____
(Include pregnancy within 3 months of death)

11. Industry or business at home

Major findings: _____
 Of operations _____

12. Name William Luby

Of autopsy _____

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

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

14. Maiden name Bessie Houston

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

16. (a) Informant _____
 (b) Address 5351 West Avenue

17. (a) burial (b) Date thereof 5-8-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery
Southern Funeral Home

18. (a) Signature of funeral director _____
 (b) Address 6322 South Grand Blvd

19. (a) MAY 7 (b) 1945 J. F. Budack
(Date received local registrar) (Registrar's signature)

(a) Accident, suicide, or homicide (specify) none

(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? _____

22. If death was due to external causes, fill in the following:
 While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature A. Steiner (M. D. or other) MD
 Address 634 N. Grand Date signed 5-7-45

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.....

P. O. Address.....

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.