

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

4388
Do not use this space.

FILED JAN 21 1946

1. PLACE OF DEATH
 (a) County Washington Registration District No. 366
 (b) Township Kingston Primary Registration District No. 1242
 (c) City 1 (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Fannie Guenther
 (a) Residence, No. Washington Co Mo. 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

MEDICAL CERTIFICATE OF DEATH

3. SEX F **4. COLOR OR RACE** W **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** M
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Charley Guenther
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 8 - 1875
7. AGE YEARS 75 MONTHS 6 DAYS 22 If LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House work
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) 1945 **11. Total time (years) spent in this occupation** _____
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Washington Co. Mo.
FATHER
13. NAME Christopher Hill
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown
MOTHER
15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
17. INFORMANT (ADDRESS) Mrs. Coleman
5144 Freeman Ave. St. Louis
18. BURIAL, CREMATION, OR REMOVAL PLACE Richey Mo. DATE Jan. 14 1946
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Mrs. Luther Sparks
Peteri Mo.
20. FILED Jan 14 1946 Mrs. G. F. Cross
Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 12 1946
22. I HEREBY CERTIFY, that I attended deceased from July 1945 to Jan 12 1946
 I last saw her alive on Dec 1945. Death is said to have occurred on the date stated above, at 7 A m.
 The principal cause of death and related causes of importance were as follows:
Carcenoma Rectum
 Date of onset _____
 Other contributory causes of importance:

 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____
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? _____
 If so, specify _____
 (Signed) W. H. Crosswell, M. D.
 (Address) Peteri Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.

3450

RECEIVED

District Health Officer No. 4
District File Number 146-1503
Date Filed 1-18-46

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

Edward J. ...

Licensed Embalmer No. 4787

P. O. Address Flat R

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to sign with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

Registration District No. 366

Primary Registration District No. 6242

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Washington
(b) City or town Kingston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 25 yrs. years, months or days

3. (a) PRINT FULL NAME Fannie Guenther

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife Charley Guenther 6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased July (Month) 1946 (Day) 1946 (Year)

8. AGE: Years 75 Months 6 Days 2 If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Wash.

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

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

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1946 hour _____ minute _____ M. _____

21. I hereby certify that I attended the deceased from _____ to _____ that I last saw him _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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

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 _____ (M. D. or other) _____

Address _____ Date signed _____

PRINTING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

