

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution: State Hosp # 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 mos 16 da
(Specify whether years, months or days)

In this community 3 mo - 16 da

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Starrison 11

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

(d) Street No. 14
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME JAMES H GUTHERIDGE

(b) If veteran, name war --

(c) Social Security No. not stated

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 1 year 1946 hour 11:15 minute a M.

21. I hereby certify that I attended the deceased from 9/27 1946 to 10/1 1946.
that I last saw him alive on Dec 1 1946 and that death occurred on the date and hour stated above.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife no information

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

7. Birth date of deceased March 22 1861
(Month) (Day) (Year)

Immediate cause of death Bronchial pneumonia Duration 4 da

Due to Empyema left side
Angioma both ab. arch

Due to left kidney cysts + stone

8. AGE: Years 85 Months 6 Days 8 if less than one day hr. min.

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

Major findings: Of operations 117

Of autopsy as above

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

10. Usual occupation Farmer

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 L. S. Shuck (M. D. or other) 9

Address State Hosp # 2 Date signed 10/1/46

11. Industry or business _____

12. Name James Guthridge

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

14. Maiden name RACHEL DORRELL

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

16. (a) Informant Sam Guthridge

(b) Address RIDGEWAY Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-1-46 (Month) (Day) (Year)

(c) Place: burial or cremation Bethany, Mo.

18. (a) Signature of funeral director Clark Montgomery

(b) Address 5025 Kingshighway

19. (a) Oct. 29, 1946 (Date received local registrar) (b) L. S. Shuck (Registrar's signature)

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

MOTHER FATHER

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 *Earl Clark*.....

Licensed Embalmer No. *4238*

P. O. Address *St. Joseph 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.