

FILED AUG 5 1947

Registration District No. _____

Primary Registration District No. **3000**

Registrar's No. **202**

1. PLACE OF DEATH:

(a) County **Adair**
(b) City or town **Kirksville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1007 S. Wabash Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **None**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Gertrude Edith Guthrie**

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 **Widowed**

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

7. Birth date of deceased **Jan. 11 1903**
(Month) (Day) (Year)

8. AGE: Years **44** Months **6** Days **11** If less than one day hr. _____ min. _____

9. Birthplace **Adair County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Beauty Operater**

11. Industry or business

12. Name **James B. Combs**
13. Birthplace **Unknown Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Ella Hatfield**
15. Birthplace **Unknown Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Imogene Grear**
(b) Address **Kirksville, Missouri**

17. (a) **Burial** (b) Date thereof **7/23/47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Queen City, Missouri**

18. (a) Signature of funeral director **D. T. Rhoads**
(b) Address **Kirksville, Missouri**

19. (a) **7-29-47** (b) **Date Dumber**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **California** (b) County **Los Angeles**
(c) City or town **Los Angeles**
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **22**
year **1947** hour **6:00** minute **A.M.**

21. I hereby certify that I attended the deceased from **July 22 1947** to **July 22 1947**
that I last saw him/her alive on **July 22 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Circulatory Collapse**
Due to **Extreme emaciation**
Due to **Carcinoma of bladder, vagina & colon**
Other conditions _____
(Include pregnancy within 3 months of death)

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

Major findings:
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? **2**
While at work? _____
(Specify type of place) (Means of injury)
23. Signature **D. T. Rhoads D.O.** (M. D. or other) _____
Address **Kirkville, Mo.** Date signed **7-22-47**

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

RECEIVED
District Health Officer No. 10
District File Number 8-47-982
Date Filed AUG - 4 1947

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.....

..... Kenneth Slavens, Registered Apprentice No. 418
working under my personal supervision.

Signed DEE Riley
Licensed Embalmer No. 4181

P.O. Address Kirksville, Missouri

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.