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

FILED JUN 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21098

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4921

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St.Louis
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5183 Cabanne Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo.
b. COUNTY none
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St.Louis
d. STREET ADDRESS (If rural, give location) 5 - 5183 Cabanne Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) b. (Middle) c. (Last) Dr.Charles Nicholas Guhman

4. DATE OF DEATH (Month) (Day) (Year) June 5,1949

5. SEX M.
6. COLOR OR RACE W.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S.
8. DATE OF BIRTH Oct.14,1874
9. AGE (In years last birthday) 74 — If under 1 year: Months 7, Days 21; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) St.Louis,Mo.
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Dr.Nicholas Guhman
13b. MOTHER'S MAIDEN NAME Henrietta Meissner
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) World # I
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME Mr.Elzear Rohan, **ADDRESS** 4645 Sherley

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart disease & Myasthenia gravis — INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* None

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION None
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify) No
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) None m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1945, *to* 6-5, 1949, *that I last saw the deceased alive on* 6-5, 1949, *and that death occurred at* 4 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE John J Hammond (Degree or title) M.D.
23b. ADDRESS 634 N. Grand
23c. DATE SIGNED 6/6/49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE June 8,1949
24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
24d. LOCATION (City, town, or county) St.Louis,Mo. (State)

DATE REC'D BY LOCAL REG. JUN 6 1949
REGISTRAR'S SIGNATURE J B Lasater
25. FUNERAL DIRECTOR'S SIGNATURE Arthur J Donnell **ADDRESS** 5840 Lindell Blvd.

(Licensed Embalmer's Statement on Reverse Side)

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 ..... Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

JUL 1 1949

Signed W H Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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

If this body is not embalmed, fact should be so stated above.