

FILED SEP 1 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 28286  
Registrar's No. 7483

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 7483	
1. PLACE OF DEATH a. COUNTY 0				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. LENGTH OF STAY (In this place) 25		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		2259	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hospital				d. STREET ADDRESS (If rural, give location) 1602 Cass Ave. 0			
3. NAME OF DECEASED (Type or Print) a. (First) Bertie		b. (Middle) Eva		c. (Last) Guthrie		4. DATE OF DEATH (Month) (Day) (Year) Aug. 22, 1951	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH March 3, 1906	
9. AGE (In years last birthday) 45		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Scott Co., Ill.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Harvey Eldridge		13b. MOTHER'S MAIDEN NAME Linnie Elkins		14. NAME OF HUSBAND OR WIFE Edward	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Harry Eldridge, 1604 Cass Ave.			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) left heart failure myocarditis ANTECEDENT CAUSES (b) hypertensive Coarctation Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) secondary anemia II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 2 days	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		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) (Min.)	
21e. INJURY OCCURRED WHILE AT WORK? <input type="checkbox"/> NOT WHILE AT WORK? <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? HFX					
22. I hereby certify that I attended the deceased from May 1951, to Aug 22, 1951, that I last saw the deceased alive on Aug 2, 1951, and that death occurred at 11:00 A.M., from the causes and on the date stated above.							
23a. SIGNATURE D. J. Verda M.D.				23b. ADDRESS 4500 Olive St.		23c. DATE SIGNED 8-22-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 8-22-51		24c. NAME OF CEMETERY OR CREMATORY Charleston, Mo.		24d. LOCATION (City, town, or county) (State)	
DATE FILED BY LOCAL REG. Aug 22 1951		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.			

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

Mrs. Bertie Guthrie

**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

Signed

*Robert M. Murray*

Licensed Embalmer No. *3749*

P. O. Address *St. Louis, 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.