

Health, Welfare, Public Service

FILED APR 3 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-011697

STATE FILE NUMBER

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

3543

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-57
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WISCONSIN</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Cashton</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <u>8</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		Length of stay in 1b <u>3.3</u>	d. STREET ADDRESS (If outside, give location) <u>3.3</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>EILEEN</u> Middle <u>I.</u> Last <u>GUTIERREZ</u>			4. DATE OF DEATH <u>MARCH 28, 1958</u> Month <u>March</u> Day <u>28</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 19, 1924</u>	9. AGE (In years last birthday) <u>33</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>House Wife</u>	11. BIRTHPLACE (City and state or country) <u>Monroe County Wisc. /</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>George Schreier</u>	13b. MOTHER'S MAIDEN NAME <u>Agatha VanRuden</u>	14. NAME OF HUSBAND OR WIFE <u>Maj. Hector P. Gutierrez</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NONE</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>MAJ. H. P. GUTIERREZ, US ARMY FORT CARLEER ARK</u> Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>ACUTE LYMPHOCYTIC LEUKEMIA</u>	
	DUE TO (c) <u>204.3</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>/</u>
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from MARCH 25, 1958 to MARCH 28, 1958 and last saw her/him alive on MARCH 28, 1958
Death occurred at 2:00 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>C. P. McMillan M.D.</u>	22b. ADDRESS <u>BARNES HOSPITAL</u>	22c. DATE SIGNED <u>3/28/58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>3-27-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SACRO HART CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>CASHTON, WISC.</u>
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24. FUNERAL DIRECTOR <u>WHITE FUNERAL HOME 116 N. FLORESSANT</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>MAR 28 '58</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u> <u>M.D.</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

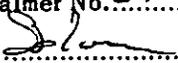
All diseases in Part I must be causally related.

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
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 3403
P. O. Address 

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.