

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-014613  
STATE FILE NUMBER

FILED APR 23 1958

Registration District No. 150 Primary Registration District No. 5572 Registrar's No. 82

300  
1-57

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1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> <u>7005</u>	
b. CITY OR TOWN <u>Rural Prairie</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Independence</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <u>10</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jackson County Hosp</u> Length of stay in lb <u>15 days</u>		d. STREET ADDRESS (If outside, give location) <u>910 S. Liberty</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Lydia Elise</u> Middle <u>Guhlman</u> Last <u>Guhlman</u>			4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1958</u>		
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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>Oct. 16-1884</u>	9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Femme Osage, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>John Duebbert</u>	13b. MOTHER'S MAIDEN NAME <u>Marie Duttendack</u>	14. NAME OF HUSBAND OR WIFE <u>Charles Guhlman</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)	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs. Amanda Borgman - Blues prs. Mo.</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>Cerebral thrombosis</u>	INTERVAL BETWEEN ONSET AND DEATH
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. }  
DUE TO (b) \_\_\_\_\_  
DUE TO (c) ARTERIO Sclerosis 332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Gangrene of Foot</u>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>3-24-58</u> to <u>4-8-58</u> and last saw her alive on <u>4-7-58</u> Death occurred at <u>2:00</u> <u>A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>Paul W. ...</u> (Degree or title)	22b. ADDRESS <u>Jackson County Hospital</u>	22c. DATE SIGNED <u>4-8-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Apr. 11, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	23d. LOCATION (City, town, or county) (State) <u>Indep. Mo.</u>
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24. FUNERAL DIRECTOR <u>Otto Mitchell - Indep. Mo.</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>4-10-1958</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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doctor, coroner, etc., must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

430

APR 22 1931

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 *Henry H. Mitchell*

Licensed Embalmer No. 3925

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