

Health,  
Welfare  
Public  
Service

FILED VS AUG 12 1959

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-025698

Registration District No. 162 Primary Registration District No. 5594 STATE FILE NUMBER 76  
Registrar's No. 76

1. PLACE OF DEATH a. COUNTY <u>JEFFERSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>1</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>RURAL-MERAMEC</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Hill Infirmary</u>		Length of stay in 1b <u>11 Months</u>	d. STREET ADDRESS (If outside, give location) <u>4312 DeSoto</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>LEO</u> Middle <u>EDWARD</u> Last <u>GUYOT, Sr.</u>			4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOVEMBER 15, 1880</u>		9. AGE (In years) <u>78</u> 10. FUNDERS 11. UNDER 1 YEAR 12. UNDER 24 HRS Months Days Hours Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MACHINIST</u>		11. BIRTHPLACE (City and state or country) <u>JACKSONVILLE, ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>LEON GUYOT</u>		13b. MOTHER'S MAIDEN NAME <u>MARGARET ROUFF</u>		14. NAME OF HUSBAND OR WIFE <u>ELIZABETH McELROY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT Address <u>Bro. Roch St. Joseph's Hill Infirmary EUREKA</u>			

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>BRONCHIAL PNEUMONIA</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>		
	DUE TO (c) <u>PARKINSON</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200

19. WAS AUTOPSY PERFORMED? YES  NO  2

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.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.			20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			

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	
21. I attended the deceased from <u>AUGUST 6 '58</u> to <u>JULY 31, '59</u> and last saw him alive on <u>JULY 31, '59</u> Death occurred at <u>JULY 31 '59</u> <u>8:10 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									

22a. SIGNATURE <u>J. Mander</u>			(Degree or title)			22b. ADDRESS <u>St. Joseph's Hill Infirmary Eureka</u>			22c. DATE SIGNED <u>7/31/59</u>			
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>8/3/59</u>		23c. NAME OF CENETERY OR CREMATORY <u>CALVARY CEMETERY</u>			23d. LOCATION (City, town, or county) <u>ST LOUIS MISSOURI</u>			(Note)		

24. FUNERAL DIRECTOR <u>STROOT - CARROLL 4600 NATURAL BRIDGE</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>8-3-59</u>		26. REGISTRAR'S SIGNATURE <u>Robert E. Bauer</u>			
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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33-27-307

1 1 1959

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 *MW Rueter* \_\_\_\_\_

Licensed Embalmer No. *4865* \_\_\_\_\_  
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.