ISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3342 STATE FILE NUMBER 61-010893

FILED APR 14 1961

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY

b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis — Length of stay in 1b 35 Yrs.

c. CITY OR TOWN St. Louis — Inside Limits Yes ☒ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Louis-Little Rock Hospital, Inc. — Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 955 Bates St. — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Clarence Middle Buell Last Guion

4. DATE OF DEATH Month April Day 7 Year 1961

5. SEX Male

6. COLOR OR RACE White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 9-2-1886

9. AGE (last birthday) 74 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pensr. Loco Fireman

10b. KIND OF BUSINESS OR INDUSTRY Railroad

11. BIRTHPLACE (City and state or country) Unk. Missouri

12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Antoin Guion

13b. MOTHER'S MAIDEN NAME Callie Thornhill

14. NAME OF HUSBAND OR WIFE Louise

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. Yes(Unknown)

17. INFORMANT Louise Guion, Address 956 Bates, St. Louis, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIAC FAILURE, ACUTE CONGESTIVE — INTERVAL BETWEEN ONSET AND DEATH 11 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE

DUE TO (c) 420.0

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

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 3/25/61 to April 7, 1961 and last saw him alive on April 7, 1961

Death occurred at 1:45 P.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) R C Denman, MD

22b. ADDRESS 1755 S. Grand Blvd.

22c. DATE SIGNED 4/8/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 4/10/61

23c. NAME OF CEMETERY OR CREMATORY St. Trinity

23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.

24. FUNERAL DIRECTOR ADDRESS McLaughlin Funeral Home-St. Louis, Mo.

25. DATE RECD. BY LOCAL REG. APR 10 1961

26. REGISTRAR'S SIGNATURE Earl Smith M.D.

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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. 4557

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.