

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-036707

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 139 Primary Registration District No. _____ Registrar's No. 62 STATE FILE NUMBER

AMENDED FILED OCT 24 1961

1. PLACE OF DEATH a. COUNTY <u>HOLT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>HOLT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MOUND CITY</u>		Length of stay in 1b <u>3 WKS.</u>	c. CITY OR TOWN <u>MOUND CITY</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>DUNCAN NURSING HOME</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>EVALINE THOMAS GUTHRIE</u>			4. DATE OF DEATH <u>OCT. 14, 1961</u>		
First	Middle	Last	Month	Day	Year

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>10-8-1874</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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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 <u>IN THE HOME</u>	11. BIRTHPLACE (City and state or country) <u>BOWLING GREEN, KY.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>JOHN WESLEY CARTER</u>	13b. MOTHER'S MAIDEN NAME <u>HARRIETT CARTER</u>	14. NAME OF HUSBAND OR WIFE <u>JOSEPH A. GUTHRIE</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>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>OPAL ROBINSON, MOUND CITY, MO.</u>
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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>Cancer Ear with metastases in Brain</u>		INTERVAL BETWEEN ONSET AND DEATH <u>19 months</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)	DUE TO (b)	
	DUE TO (c)	

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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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 <u>March 6-60</u> to <u>Oct 14-61</u> and last saw her alive on <u>Oct 13-61</u> Death occurred at <u>3</u> <u>P</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>D. Perry M.D.</u> (Degree or title)	22b. ADDRESS <u>MOUND CITY MO.</u>	22c. DATE SIGNED <u>10-16-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>10-16-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MOUNT HOPE</u>	23d. LOCATION (City, town, or county) (State) <u>MOUND CITY, MISSOURI</u>
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24. FUNERAL DIRECTOR ADDRESS <u>JAMES H. CRAWFORD, MOUND CITY, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>10-16-1961</u>	26. REGISTRAR'S SIGNATURE <u>James H. Crawford</u>
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DATE AMENDED

INSTEAD OF DOCUMENT

BY AFFIDAVIT OF

ITEM NO. STICKEAD READ

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 James H. Crawford

Licensed Embalmer No. 4796

P. O. Address Mound City,

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.