DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 4545

Registration District No. 791 — FILED MAR 12 — Primary Registration District No. 1003 — Registrar's No. 1375

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis Missouri (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: BARNES HOSPITAL (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution / (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State INDIANA (b) County

(c) City or town ATLANTA NR (If outside city or town limits, write "RURAL")

(d) Street No. R.R. 2 (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME 350 EDRIE LEAH GUTHRIE

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Glenn Guthrie

6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased May 2, 1906 (Month) (Day) (Year)

8. AGE: Years 33 Months 9 Days 8 If less than one day hr. min.

9. Birthplace Tipton (City, town, or county) Indiana (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Shady K. Stansbury
13. Birthplace Saybrook (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name Mae Racobs
15. Birthplace Tipton (City, town, or county) Indiana (State or foreign country)

16. (a) Informant's own signature Glenn Guthrie

(b) Address Atlanta, Indiana

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/13/40 (Month) (Day) (Year)

(c) Place: burial or cremation Atlanta, Indiana

18. (a) Signature of funeral director Albert H. HOppe Inc

(b) Address 4700 Washington Blvd.

19. (a) FEB 11 1940 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEBRUARY day 10 year 1940 hour 8 minute 15 A.M.

21. I hereby certify that I attended the deceased from JANUARY 15, 1940, to FEBRUARY 10, 1940; that I last saw HER alive on FEBRUARY 10, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Brain abscess non-tubercular (multiple) caused by septicemia	4 days
Due to Bronchiectasis - left lower - post-operative	33 yrs.
Due to	
Other conditions (Include pregnancy within 3 months of death)	

78a

Major findings: Of operations Bronchiectasis

Of autopsy Multiple Brain abscesses streptococci staphlococci

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature FR Bradley (M. D. or other)

Address BARNES HOSPITAL Date signed

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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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 Wilford Burnley, Registered Apprentice No. 1 working under my personal supervision.

Signed Albert N. Happe

Licensed Embalmer No. 1861

P. O. Address 4700 Washington

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 this body is not embalmed, above space should be left blank.