S. No. 2
M—2-43
. 5-17-39
I X35697

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 7 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25708

Registration District No. 8145 Primary Registration District No. 1003 Registrar's No. 7575

1. PLACE OF DEATH:

(a) County St. Louis
(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 2501 a Glasgow 1 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community 40 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000
(c) City or town St. Louis 17 (If outside city or town limits, write "RURAL")
(d) Street No. 2501 a Glasgow 9 (If rural, give location)
(e) Citizen of foreign country? no 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Nettie Guinn

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex female 1

5. Color or race white

6. (a) Single, widowed, married, divorced widow 1

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug 25, 1869 (Month) (Day) (Year)

8. AGE: Years 76 Months 0 Days 3 If less than one day ..... hr. ..... min.

9. Birthplace Ill. 1 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Self

MOTHER FATHER

12. Name John W. Smith

13. Birthplace Ill. 1 (City, town, or county) (State or foreign country)

14. Maiden name Mattie Smith

15. Birthplace Ill. 1 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Mary Sigler
(b) Address 2501 a Glasgow

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Joseph A. Howard
(b) Address 1619 S. Grand

19. (a) AUG 30 1945 (Date received local registrar) (b) J. F. Breech (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 28 year 1945 hour 1 minute 10 P.M.

21. I hereby certify that I attended the deceased from Oct 15, 1944 to 8-28, 1945; that I last saw him alive on 8-28-45, 19..... and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic myocarditis	
Due to: General arterial-sclerosis	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: 93 d	
Of autopsy:	

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) no
(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 Lloyd L. Weid (M. D. or other)
Address 27 Big N. Grand Date signed 8/29/45

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Jos A. Howard

Licensed Embalmer No. 4139.

P. O. Address.....

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, fact should be so stated above.