No. 2
-1/47
-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 29 1947

Registration District No. 3477

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 36635

Registrar's No. 2209

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Koch (rural)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Robert Koch Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 99 days (Specify whether
In this community 2 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 3524a Texas 9
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Guthrie, Richard Arlie

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased August (Month) 23 (Day) 1929 (Year)

8. AGE: Years 18 Months 1 Days 26 If less than one day hr. min.

9. Birthplace Hannibal (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Factory Worker

11. Industry or business

FATHER
12. Name Arlie Earl Guthrie
13. Birthplace Hannibal (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Marie Catherine Elder
15. Birthplace Hannibal (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant Hospital Records
(b) Address Robert Koch Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/47 (Month) (Day) (Year)
(c) Place: burial or cremation Hannibal, Missouri

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) 10-20-47 (Date received local registrar) (b) Cecil A. Sharp MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 18
year 1947 hour 12 minute 10 A. M.

21. I hereby certify that I attended the deceased from 7-11- 1947 to 10-18- 1947;
that I last saw him alive on 10-18- 1947;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	2½ yrs. (??)
Due to	
Due to 13	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause of 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 William A. Horner (M. D. or other) MD
Address Robert Koch Hospital Date signed 10-18-47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

NOV 3 1947

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 Elmo R. Cadwell

Licensed Embalmer No. 4077

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.