

FILED JUL 3 1948

Registration District No. **318**Primary Registration District No. **1003**

## 1. PLACE OF DEATH:

(a) County.....**St. Louis Missouri**  
 (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, 0**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **11 days**  
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME **GUERETT W. Ewing**3. (b) If veteran, name war **World War I**3. (c) Social Security No. **706-18-0709**4. Sex **Male 0** 5. Color or race **White**6. (a) Single, widowed, married, divorced **Married**6. (b) Name of husband or wife **Hazel Ewing**6. (c) Age of husband or wife if alive **53** years7. Birth date of deceased **March 9 1893**  
(Month) (Day) (Year)8. AGE: Years **55** Months **3** Days **14** If less than one day hr. min.9. Birthplace **Neoga Illinois**  
(City, town, or county) (State or foreign country)10. Usual occupation **Station Agent**11. Industry or business **Nickel Plate R.R.**12. Name **Elbert Ewing**13. Birthplace **Neoga Illinois**  
(City, town, or county) (State or foreign country)14. Maiden name **Amanda Wilson**15. Birthplace **Neoga Illinois**  
(City, town, or county) (State or foreign country)16. (a) Informant **Hazel Ewing**(b) Address **Neoga, Ill.**17. (a) **Removal** (b) Date thereof **6-23-48**  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Neoga, Ill.**18. (a) Signature of funeral director **Albert H. Hoppe**(b) Address **4700 Washington Blvd.**19. (a) **JUN 25 1948** (b) **J.F. Bredek**  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State **Illinois** (b) County **Cumberland 999**  
 (c) City or town **Neoga**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **N.R.** (If rural, give location)  
 (e) Citizen of foreign country? (Yes or No) **2**  
 If yes, name country

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **23**  
year **1948** hour **4** minute **15 A.M.**21. I hereby certify that I attended the deceased from **June 13**, 19**48**, to **June 23**, 19**48**  
that I last saw him alive on **June 23**, 19**48**  
and that death occurred on the date and hour stated above.Immediate cause of death **Carcinoma of lung with metastases to cervical spine**

Due to.....

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)Major findings:  
Of operations.....

Of autopsy.....

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) (e) Means of injury

While at work?.....

23. Signature **FR Bradley** (M. D. or other)Address **Barnes Hospital,** Date signed **4/23/48**

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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.....

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed

*John S. Dennis*  
.....  
Licensed Embalmer No. *4194*  
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.**