

86764

MISSOURI DIVISION OF HEALTH  
**STANDARD CERTIFICATE OF DEATH**

State File No. **20915**  
Registrar's No. **5551**

Registration District No. **318**

Primary Registration District No. **1003**

**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:  
St. Louis City Hospital - Max C. Starkloff  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 40 years  
years, months or days

3. (a) PRINT FULL NAME CATHERINE GUTHRIDGE

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex FEMALE 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife Wm Guthridge 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased June 22 1893  
(Month) (Day) (Year)

8. AGE: Years 54 Months 11 Days 25 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation House wife

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name John Ford  
13. Birthplace Springfield Ill  
(City, town, or county) (State or foreign country)  
14. Maiden name Catherine Rock  
15. Birthplace Springfield Ill  
(City, town, or county) (State or foreign country)

16. (a) Informant Wm Guthridge  
(b) Address 2327 Warren St

17. (a) Burial (b) Date thereof 6 21 48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director St. Louis Funeral Home  
(b) Address 2205 St. Louis ave

19. (a) JUN 20 1948 (b) J. Y. Shen  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County 00019  
(c) City or town St. Louis (If outside city or town limits, write "RURAL")  
(d) Street No. 2327 Warren St Memorial (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month June day 17th  
year 1948 hour 12 minute 05 Noon

21. I hereby certify that I attended the deceased from 6/13/48  
June 17th 1948  
er June 17th 1948  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Heart Failure & thromb  
Duration \_\_\_\_\_

Due to Meningococci & meningitis  
Due to \_\_\_\_\_

Other conditions: oto  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
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) \_\_\_\_\_  
(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?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature 1515 Lafayette 6/27/48 (Other)  
Address Jerome T. Y. Shen Date signed \_\_\_\_\_

*Mil*

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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

*Gustavo W. Quintana*

Licensed Embalmer No.

*4329*

P. O. Address

*St. Louis*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**