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FEDERAL SECURITY AGENCY

National Office of Vital Statistics

FILED SEP 24 1948

318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. _____

8167

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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, 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 17 days (Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME James E. Guyton

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

4. Sex Male 5. Color or race Negro 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 March 6 1930
(Month) (Day) (Year)

8. AGE: Years 18 Months 6 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace Joplin, Miss.
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business _____

12. Name Edward Guyton

13. Birthplace Centon, Miss.
(City, town, or county) (State or foreign country)

14. Maiden name Trudie Franer

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

16. (a) Informant Edward Guyton

(b) Address 4321 Galveston

17. (a) Shipment (b) Date thereof 9/18/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Hill, Miss.

18. (a) Signature of funeral director _____

(b) Address 4214 Delmar Blvd

19. (a) SEP 18 1948 (b) J. F. Bradack
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____

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

(d) Street No. 1514 Taylor
(rural, give location)

(e) Citizen of foreign country? _____ (Specify No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 17
year 1948 hour 7 minute 25 AM.

21. I hereby certify that I attended the deceased from August 31,
19 48 to September 17, 19 48
that I last saw him alive on September 17, 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death: Cirroid aneurysm, right cerebral hemisphere.

Due to _____

Due to _____

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

Major findings: Of operations Right fronto-parietal craniotomy with excision of aneurysm
Of autopsy None performed.

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? _____ (c) Means of injury _____

23. Signature H. Bradley (M. D. or other) _____
Address Barnes Hospital, Date signed 9/17/48

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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 F. A. Green
Licensed Embalmer No. 2963
P. O. Address: 1914 Delmar

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.