

FILED APR 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13793

State File No. 3328
Registrar's No. 1003

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE		b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give town)		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township)			
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS					
3. NAME OF DECEASED (Type or Print) a. (First) Lena			b. (Middle) Guthrie				
c. (Last) Guthrie			4. DATE OF DEATH (Month) (Day) (Year) April 10, 1949				
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married			
8. DATE OF BIRTH 3/30/1885		9. AGE (In years last birthday) 64		10. IF UNDER 1 YEAR Months Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Jonesburg, Tennessee			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Larkin Ford		13b. MOTHER'S MAIDEN NAME Unis Ferguson			
14. NAME OF HUSBAND OR WIFE Oglen Guthrie		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None			
17. INFORMANT'S SIGNATURE OR NAME Oglen Guthrie		17. ADDRESS 4233 W. Maffitt Ave.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES. Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 830 331X				INTERVAL BETWEEN ONSET AND DEATH 7 days unknown	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR			
22. I hereby certify that I attended the deceased from Jan 2, 1949 , to Apr. 8, 1949 , that I last saw the deceased alive on Apr. 5, 1949 , and that death occurred at 12:42 P.M. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) C. Basile Poor, M.D.			23b. ADDRESS 1730 Franklin Avenue		23c. DATE SIGNED		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4/18/49		24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
DATE REC'D BY LOCAL REG. APR 13 1949		REGISTRAR'S SIGNATURE J.P. Foster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Chas. J. Gates, 4107 Finney Ave.			

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

APR 14 1949

(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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Thomas J. Miller

Signed _____
Student Embalmer

Licensed Embalmer No. ~~4476~~ 4859

P. O. Address 4107 Finney Avenue

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.