

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31515**
Registrar's No. **7956**

FILED SEP 22 1951

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).	
b. CITY (If outside corporate limits, write RURAL and give township) St. Johns		a. STATE Mo.	
c. LENGTH OF STAY (In this place)		b. COUNTY	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hosp.		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
		d. STREET ADDRESS (If rural, give location) 2863 Missouri Av.	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)	
Genevieve Florence Guttman			Sept 6 1951	
5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)
Female	white	married	Aug. 10 1885	66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Housewife				Michigan
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME		
U.S.A.		Charles Ellis		
		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE
		Deborah Wellborn		Anton Guttman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME		ADDRESS
no	no	Anton Guttman		2863 Missouri

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		19. INTERVAL BETWEEN ONSET AND DEATH 17 days
	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.	

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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 321X

22. I hereby certify that I attended the deceased from **May 11**, 19**49**, to **9-6**, 19**51**, that I last saw the deceased alive on **9-6**, 19**51**, and that death occurred at **3:45 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) A. K. Frisk MD.	23b. ADDRESS 3604 Washington	23c. DATE SIGNED 9-7-51
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY
cremation	9-8-51	Mo. Crematory
24d. LOCATION (City, town, or county) (State)		
St. Louis Mo.		

DATE RECD BY LOCAL HEALTH DEPT. SEP 7 1951	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	FUNERAL DIRECTOR'S SIGNATURE Witt Brothers	ADDRESS 2929 S. Jefferson Av.
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

H. M. Davis

Signed.....
Student Embalmer

Licensed Embalmer No. *3741*

P. O. Address *2929 Jefferson*

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.