

FILED MAY 6 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **13499**  
**3795**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G. Phillips Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>3000 Easton</b> <b>21</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Hugo</b> b. (Middle) _____ c. (Last) <b>Guice</b>			4. DATE OF DEATH (Month) <b>4</b> (Day) <b>22</b> (Year) <b>54</b>				
5. SEX <b>M</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>11/20/01</b>	
9. AGE (In years last birthday) <b>52</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Freighthandler</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Monrouge La</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13a. FATHER'S NAME <b>Robert Guice</b>		13b. MOTHER'S MAIDEN NAME <b>Emma ?</b>		14. NAME OF HUSBAND OR WIFE <b>Ethel Guice</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>489-10-6135</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Ethel Guice</b> ADDRESS <b>3000a Easton Ave.</b>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Malignant Hypertension; Uremia</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>Undt.</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <b>445 X</b> (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 <b>3-23</b> , 19 <b>54</b> , to <b>4-22</b> , 19 <b>54</b> , that I last saw the deceased alive on <b>4-22</b> , 19 <b>54</b> , and that death occurred at <b>5:25P</b> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>E. B. Williams</b> M.D.				23b. ADDRESS <b>2601 N. Whittier</b>		23c. DATE SIGNED <b>4-23-54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>motor</b>		24b. DATE <b>4/28/54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>	
DATE REC'D BY LOCAL REG. <b>APR 27 1954</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>		FUNERAL DIRECTOR'S SIGNATURE <b>Grant Johnson</b> ADDRESS <b>4352 Wash. Blvd.</b>			

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

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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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed..... *F. A. Green*

Licensed Embalmer No. *29*

P. O. Address *4214 Sed*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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