

FILED JUN 24 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **20562**  
Registrar's No. **4861**

BIRTH NO.		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		State File No. <b>20562</b>		Registrar's No. <b>4861</b>									
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>2069</b>													
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"/> <b>0</b>											
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>6 5102a Lotus Avenue</b>													
3. NAME OF DECEASED (Type or Print) a. (First) <b>Amelia</b>			b. (Middle)			c. (Last) <b>Guest</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>6 - 1 - 1954</b>								
5. SEX <b>Fem /</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed 2</b>		8. DATE OF BIRTH <b>10 - 15 - 1868</b>		9. AGE (In years last birthday) <b>85</b>		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 24 HRS. Hours		IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>				11. BIRTHPLACE (City and State or Foreign Country) <b>New York, N. Y. /</b>				12. CITIZEN OF WHAT COUNTRY?					
13a. FATHER'S NAME <b>unknown Willibaldt</b>				13b. MOTHER'S MAIDEN NAME <b>unknown</b>				14. NAME OF HUSBAND OR WIFE <b>John H. Guest</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.				17. INFORMANT'S SIGNATURE OR NAME <b>John A. Guest, 5102 Lotus Avenue</b>				ADDRESS					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION										INTERVAL BETWEEN ONSET AND DEATH					
<p>* This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cholera, Typhoid, Sepsis</b>															
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Sensitivity</b> 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)		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>Apr. 19, 1946</b> to <b>June 1, 1954</b> that I last saw the deceased alive on <b>May 31, 1954</b> and that death occurred at <b>12:35 A.</b> , from the causes and on the date stated above.																	
23a. SIGNATURE (Degree or title) <b>Edward J. Heltman MD</b>						23b. ADDRESS <b>3903 Olive (S)</b>				23c. DATE SIGNED <b>6-1-54</b>							
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>6/3/54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>				24d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>									
DATE REC'D BY LOCAL REG. <b>JUN 1 1954</b>		REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>				25. FUNERAL DIRECTOR'S SIGNATURE <b>Drehmann-Harral</b>				ADDRESS <b>1905 Union Blvd.</b>							

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

Dr. Edw. J. Helbling  
3903 Olive

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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..... *Albert R. Thompson*

Licensed Embalmer No. *423*

P. O. Address *H. J. ...*

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.