

FILED MAY 9 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 12566

BIRTH NO. _____		REG. DIST. NO. <u>385</u>		PRIMARY REG. DIST. NO. <u>3039</u>		Registrar's No. <u>37</u>	
1. PLACE OF DEATH a. COUNTY <u>Linn</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO</u> b. COUNTY <u>CHARITON</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>MARCELINE</u>		c. LENGTH OF STAY (In this place) <u>1 6 Mon</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>MARCELINE</u>		0210 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. FRANCIS HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>ROUTE 1</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>MARY</u> b. (Middle) <u>ELLEN</u> c. (Last) <u>GUTHRIE</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>4</u> <u>23</u> <u>55</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>	8. DATE OF BIRTH <u>10.17/1859</u>		9. AGE (In years last birthday) <u>95</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u>	IF UNDER 4 HRS. Hours <u></u> Mins. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Chariton Co. 0</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>PETER S MITH</u>		13b. MOTHER'S MAIDEN NAME <u>ELLEN OWEN</u>		14. NAME OF HUSBAND OR WIFE <u>ROBERT (DECEASED)</u>			
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 <u>MRS. JIM ROBINSON KEYTESVILLE, MO</u>			
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, assthenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Streamline, Bilateral</u>  ANTECEDENT CAUSES <u>Cerebral Thrombosis</u> DUE TO (b) <u></u> DUE TO (c) <u></u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>490 X</u>				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) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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 <u>10:45 to April 23, 1955</u> , that I last saw the deceased alive on <u>April 23, 1955</u> , and that death occurred at <u>7:30</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Mary Jane Ridgway M.D.</u>				23b. ADDRESS <u>Marceline, Mo. 64555</u>		23c. DATE SIGNED <u>4-25-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		24b. DATE <u>4/26/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>MT. PLEASANT</u>		24d. LOCATION (City, town, or county) (State) <u>CHARITON CO MO</u>		
DATE REC'D BY LOCAL REG. <u>4-23-55</u>		REGISTRAR'S SIGNATURE <u>Mary Jane Ridgway</u>		401- 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>James M. Soughlin Marceline</u>			

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

OCT 7 1955

AUG 20 1956

MAY 10 1955

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 .....  
Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.