

FILED JUN 14 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17939

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5117**

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). -- a. STATE Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	c. LENGTH OF STAY (in this place) _____	c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION 5610 Theodosia Avenue		e. STREET ADDRESS (If rural, give location) 5610 Theodosia Avenue 200 1/2	

3. NAME OF DECEASED (Type or Print) a. (First) Marie b. (Middle) _____ c. (Last) Guentert	4. DATE OF DEATH (Month) (Day) (Year) 5 - 27 - 1956
--	---

5. SEX Fem	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 3 - 17 - 1876	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
-------------------	-------------------------------	---	---------------------------------------	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (City and State or Foreign Country) Hamburg, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
--	--	---	---

13a. FATHER'S NAME Ferdinand Leigh	13b. MOTHER'S MAIDEN NAME Ernestine Weyhrauch	14. NAME OF HUSBAND OR WIFE Joseph Guentert
---	--	--

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 Forest L. Guentert ADDRESS 5610 Theodosia
--	-------------------------------------	---

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		INTERVAL BETWEEN ONSET AND DEATH	
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure			2 wks
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis (Cardiovascular) Des DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			Unknown	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION 422.1	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) _____	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 **5/22, 1956**, to **5/27, 1956**, that I last saw the deceased alive on **5/27, 1956** and that death occurred at **1:45 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Robert A. Bauer MD	23b. ADDRESS 3731 Goodfellow	23c. DATE SIGNED 5/28/56
--	-------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 5/31/56	24c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County Mo.
--	--------------------------	---	---

DATE REC'D BY LOCAL REG. MAY 28 1956	REGISTRAR'S SIGNATURE J. Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Drehmann-Harral ADDRESS 1905 Union Blvd.
---	---	---

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

Dr. Robt. Bauer
3731 Goodfellow Ave.

1 - 4

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Warren A. Carver*.....

Licensed Embalmer No. *35*.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fa
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.