

FILED JUL 26 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26155**

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

Registrar's No. **6324**

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE ILLINOIS b. COUNTY RANDOLPH	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. LENGTH OF STAY (in this place) 2 days	c. CITY OR TOWN CHESTER
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 14 JEWISH HOSPITAL		e. STREET ADDRESS (If rural, give location) 32 504 BEM STREET 8/28	
3. NAME OF DECEASED (Type or Print) a. (First) GALE b. (Middle) ANN c. (Last) GUETHLE		4. DATE OF DEATH (Month) (Day) (Year) JULY 4 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH JULY 1, 1957
9. AGE (In years last birthday) -	IF UNDER 1 YEAR (Months) -	IF UNDER 1 YEAR (Days) 3	IF UNDER 24 HRS. (Hours) (Min.) -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and State or Foreign Country) CHESTER, ILLINOIS
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME ROY GUETHLE	
13b. MOTHER'S MAIDEN NAME ALICE JONES		14. NAME OF HUSBAND OR WIFE NONE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. (If yes, give war or date of service) NO	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Roy Guethle CHESTER, ILL.	
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) Prematurity (8 mos) 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. Encephalocoele	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 751x	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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?	
22. I hereby certify that I attended the deceased from July 3, 1957 , to July 4, 1957 , that I last saw the deceased alive on July 4, 1957 ; and that death occurred at 3:40 Pm. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Daniel Moore MD		23b. ADDRESS Jewish Hosp of St. Louis	23c. DATE SIGNED 7-5-57
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 7-6-57	24c. NAME OF CEMETERY OR CREMATORY EVERGREEN	24d. LOCATION (City, town, or county) (State) CHESTER, ILL
DATE REC'D BY LOCAL REG. JUL 8 57	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Welge - Chester - Ill.	

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

Student.....
Signature of 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.