

Dr. Duncan  
GUSE

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-009087  
STATE FILE NUMBER

FILED APR 14 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 358

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		c. CITY OR TOWN <b>SPRINGFIELD 6396</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. JOHN'S HOSP.</b>		Length of stay in lb <b>61 YRS.</b>	
d. STREET ADDRESS <b>1140 W. LINWOOD DR.</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>OPAL</b> Middle <b>PICKERING</b> Last		4. DATE OF DEATH Month <b>APRIL</b> Day <b>4</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 21 1897</b>
9. AGE (In years lost birthday) <b>61</b>		10. FUNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during week immediately preceding death, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) <b>SPRINGFIELD, MO. 0</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>U.S. FRENCH</b>		13b. MOTHER'S MAIDEN NAME <b>SALLY TURNER</b>	
14. NAME OF HUSBAND OR WIFE <b>GUY PICKERING</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	
17. INFORMANT <b>GUY PICKERING</b>		Address <b>SPRINGFIELD, MO.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Sigmoid &amp; generalized metastases</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1533</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>metastases</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION <b>SPRINGFIELD, MO.</b>		COUNTY STATE	
21. I attended the deceased from <b>April 17, 1957</b> to <b>April 4, 1959</b> and last saw her alive on <b>4-4-59</b> Death occurred at <b>8 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Alon F. Guse M.D.</b> (Degree or title)		22b. ADDRESS <b>302 Prof. Bldg. Springfield, Mo</b>	
22c. DATE SIGNED <b>6 April 1959</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>4/6/59</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MAPLE PARK</b>		23d. LOCATION (City, town, or county) (State) <b>SPRINGFIELD, MO.</b>	
24. FUNERAL DIRECTOR <b>H.H. LOHMEYER</b>		ADDRESS <b>SPRINGFIELD, MO.</b>	
25. DATE RECD. BY LOCAL REG. <b>4-8-59</b>		26. REGISTRAR'S SIGNATURE <b>Effie S. Melton</b>	

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *D.H. McCann* .....

Licensed Embalmer No. *2727* .....

P. O. Address *Springfield, Mo.* .....

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.