

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 14 1960

-60-008283

2 2197

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN Affton
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7808 Navajoe Dr.
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First LEONA Middle M. Last GUIGNON	4. DATE OF DEATH Month Feb. Day 24 Year 1960
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-22-1890	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Francis J. Krause	13b. MOTHER'S MAIDEN NAME Mary Mueller	14. NAME OF HUSBAND OR WIFE Late Frank J. Guignon
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mariana Bourne 7808 Navajoe Dr.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary insufficiency</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>metastatic ca of breast, lymphatic spread 1 year</u>	
	DUE TO (c) <u>170x</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>none</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT 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 COUNTY STATE
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21. I attended the deceased from <u>2/17/60</u> to <u>2/23/60</u> and last saw ^{her} _{him} alive on <u>2/23/60</u> Death occurred at <u>6:00 AM</u> <u>2/24/60</u> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>John R. West (M.D.)</u>	22b. ADDRESS <u>5535 Delmar Blvd., St. L. 12, Mo.</u>	22c. DATE SIGNED <u>2/24</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE Feb. 27, 1960	23c. NAME OF CEMETERY OR CREMATORY Missouri Crematory	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway	25. DATE RECD. BY LOCAL REG. FEB 25 1960	26. REGISTRAR'S SIGNATURE <u>Loard Smith. M.D.</u> <u>mjs</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William B White

Licensed Embalmer No. 4291

P. O. Address 228 DeKings

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.