

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 2 1960 **318**

Primary Registration District No. **1003**

Registrar's No. **7993**

-60-032267
STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 3 Weeks	c. CITY OR TOWN Ferguson
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 99 So. Clay Ave.

3. NAME OF DECEASED (Type or print) First Juanita Middle Guth Last			4. DATE OF DEATH Month August Day 11 Year 1960		
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5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-14-14	9. AGE (last birthday) 46	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) VanCleve, Miss.	12. CITIZEN OF WHAT COUNTRY U. S.
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13a. FATHER'S NAME Thomas R. Carter	13b. MOTHER'S MAIDEN NAME Jane Holden	14. NAME OF HUSBAND OR WIFE James B. Guth
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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. 491-18-2619	17. INFORMANT James B. Guth	Address Ferguson, Missouri.
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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) Adeno Carcinoma of Rectum		INTERVAL BETWEEN ONSET AND DEATH 6 mos
DUE TO (b) _____ DUE TO (c) 154x		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 type="checkbox"/> NO <input checked="" 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 a.m. p.m. 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 March 1960 to 8-11-60 and last saw her alive on 8-11-60 Death occurred at 10:05 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE W. O. Johnson M.D.	(Degree or title)	22b. ADDRESS Ferguson Mo	22c. DATE SIGNED 8-12-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-13-60	23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri.
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24. FUNERAL DIRECTOR White-Mullen Mortuary, Ferguson, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE Lead Smith, M.D.
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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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Larry M. Shultz

Licensed Embalmer No. 3970

P. O. Address Pergusa

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