N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

**PLACE OF DEATH**

County: Macon

Township: Hudson
or
Village:
or
City: Macon (NO. St.: Ward)

Registration District No. 533 — File No. 9731

Primary Registration District No. 5713 — Registered No. 31

[If death occurred in a hospital or institution, give its NAME instead of street and number]

**FULL NAME** John H Guy

**PERSONAL AND STATISTICAL PARTICULARS**

| SEX | COLOR OR RACE | SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) |
|---|---|---|
| Male | Negro | Widower |

DATE OF BIRTH: May — (Month) — (Day), 1869 (Year)

AGE: 49 yrs. 3 mos. ds. — If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Laber
(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Macon Mo

PARENTS
NAME OF FATHER: Jim Guy
BIRTHPLACE OF FATHER (City or town, State or foreign country): Macon Mo
MAIDEN NAME OF MOTHER: Dant Mo
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Dant Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Pearly Brantson

(ADDRESS) Macon Mo

Filed 4-10-, 1918. M. M. Wilhite
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH: March (Month) 20 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from March 10, 1918, to March 20, 1918, that I last saw him alive on March 20, 1918, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

108 Lobar Pneumonia

(Duration) yrs. mos. 10 ds.

Contributory (SECONDARY)
(Duration) yrs. mos. ds.

(Signed) J. E. Smith, M. D.

3-22-, 1918 (Address) 130½ Vine St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

PLACE OF BURIAL OR REMOVAL: Woodlawn
DATE OF BURIAL: 3/22, 1918

UNDERTAKER: Allnutt & Lamar
ADDRESS: Macon Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

**PLACE OF DEATH**

County.....

Township ..... or Village ..... or City .....(NO. ....., ..... St.; ..... Ward)

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

[If death occurred in a hospital or institution, give its NAME instead of street and number]

**FULL NAME** .....

**PERSONAL AND STATISTICAL PARTICULARS**

| SEX | COLOR OR RACE | SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word) |
|---|---|---|
| | | |

DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

AGE .....yrs. .....mos. .....ds.

If LESS than 1 day, .....hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191...., .....
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH

....., 191....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191...., to ....., 191...., that I last saw h..... alive on ....., 191...., and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory .....
(SECONDARY)

.....(Duration).....yrs. .....mos. .....ds.

(Signed) ..... M. D.

....., 191.... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

| PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....., 191.... |
|---|---|
| UNDERTAKER | ADDRESS |