LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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. THIS IS A PERMANENT RECORD

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

1 PLACE OF DEATH

County Henry

Township ..... or Village ..... or City Clinton Mo (No. ....., St. ....., Ward)

Registration District No. 380 File No. 19254

Primary Registration District No. 3418 Registered No. 139

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

2 FULL NAME Emmett Guyman Jr

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Boy

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word):

6 DATE OF BIRTH: May 15 (Month) 15 (Day) 1920 (Year)

7 AGE: ..... yrs. ..... mos. 2 ds.

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

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

9 BIRTHPLACE (City or town, State or foreign country): Henry Co Missouri

PARENTS

10 NAME OF FATHER: E K Guyman Sr

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

12 MAIDEN NAME OF MOTHER: Dant Kinsey

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Dant Kansas

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E K Guyman

(Address) Clinton Mo

15

Filed 5-21-1920 R. B. Bears Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May (Month) 20 (Day) 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from May 18, 1920, to May 20, 1920, that I last saw h[illegible] alive on May 20, 1920, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Malestasis

12/12

1/51

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

CONTRIBUTORY (Secondary) .....

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

(Signed) [illegible] M. D.

5/21, 1920 (Address) Clinton Mo

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

18 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 .....

19 PLACE OF BURIAL OR REMOVAL: Clinton Mo Henson

DATE OF BURIAL: 5-21-20, 1920

20 UNDERTAKER: [illegible]

ADDRESS: Clinton Mo

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County ....

Township or Village or City .... Registration District No. .... File No. ....

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

(NO. .... St., ... Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME ....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH .... (Month) .... (Day), 1 .... (Year)

7 AGE ......yrs. ......mos. ......ds. If LESS than 1 day, ...hrs. or ......min.?

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

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

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ....

(Address) ....

15

Filed ...., 191......, ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May (Month) 26 (Day), 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from May 24, 1920, to May 26, 1920, that I last saw h...... alive on May 26, 1920, and that death occurred, on the date stated above, at 12 P.m.

The CAUSE OF DEATH* was as follows:

Born head, The baby was weak from birth & never breathed right. (Duration) ......yrs. ......mos. ......ds.

CONTRIBUTORY (Secondary) .... (Duration) ......yrs. ......mos. 2 ds.

(Signed) J. S. Wallis M. D.

May 28, 191 (Address) Clinton Mo

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

18 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 ....

19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ...., 191......

20 UNDERTAKER | ADDRESS