

AUG 1 1927

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

Do not use this space.

20838

1. PLACE OF DEATH

County Salaway  
Township \_\_\_\_\_  
City Fulton (No. \_\_\_\_\_)

Registration District No. 104  
Primary Registration District No. 3008

File No. \_\_\_\_\_  
Registered No. 147  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Guy Dameron  
(a) Residence. No. Hambard Mo St., \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. 29 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF no information

6. DATE OF BIRTH (MONTH, DAY AND YEAR) no information

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. 63 no information

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carpenter  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN), \_\_\_\_\_ (STATE OR COUNTRY) Mo.

10. NAME OF FATHER no information

11. BIRTHPLACE OF FATHER (CITY OR TOWN), \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

13. BIRTHPLACE OF MOTHER (CITY OR TOWN), \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

14. INFORMANT State hospital records (Address) Fulton Mo

15. FILED 7/31 1927 R. N. Crews REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July-31-1927

17. I HEREBY CERTIFY That I attended deceased from July-10-, 1927, to July-30-, 1927 (but I last saw him alive on July-30-, 1927, and that death occurred, on the date stated above, at 3:50 a. m.)

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Atherosclerosis

CONTRIBUTORY (SECONDARY) 91B

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical symps

(Signed) T. P. Frazer, M. D.

7-31-1927 (Address) Fulton Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Hambard Mo 8/2/27

20. UNDERTAKER ADDRESS Sheldon Taylor Fulton Mo

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.

SEP 17 1954