

APR 30 1930

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

Do not use this space.

9722  
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1. PLACE OF DEATH

County *Cape Girardeau*  
Township *Johnson*  
City (No. ....) St. .... Ward .....

Registration District No. *641*  
Primary Registration District No. *5850*

File No. ....  
Registered No. ....  
St. .... Ward .....

2. FULL NAME

*Isaphine Guich*  
(a) Residence No. .... St. .... Ward .....

(If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) *Infant*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Infant*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug 23 - 1929*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min. *8 3*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Infant*  
(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) *Mo.*  
(STATE OR COUNTRY)

10. NAME OF FATHER *William Guich*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Mo.*  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Mrs. J. Harrison*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Mo.*  
(STATE OR COUNTRY)

14. INFORMANT *Robert Crater*  
(Address) *Waverly*

15. FILED *Mar 24 1930* *Robert Crater*  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *3 / 25 / 30*

17. I HEREBY CERTIFY That I attended deceased from *3/24* 19*30*, to *3/25* 19*30*, and that I last saw h. *alive* on *3/24* 19*30*, m. *3:20*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Pneumonia*  
*3rd degree*  
*181* (duration) yrs. mos. ds. *1*

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *Home*  
IF NOT AT PLACE OF DEATH.

19. DID AN OPERATION PRECEDE DEATH? *No.* DATE OF .....

20. WAS THERE AN AUTOPSY? *No.*

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *J. Gaston*, M. D.  
*3/26*, 19*30* (Address) *Meta 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 *Waverly Cemetery* DATE OF BURIAL *3/26 1930*

20. UNDERTAKER *Joe Woulff* ADDRESS *Waverly*

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

[The main body of the page contains extremely faint and illegible text, likely due to a very low quality scan or intentional redaction. The text is scattered across the page and does not form any recognizable words or sentences.]

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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Croage  
Township Jackson  
City (No. ....) St. .... Ward .....

Registration District No. 641  
Primary Registration District No. 9850

File No. 3  
Registered No. ....  
St. .... Ward .....

**2. FULL NAME**

Daphine Quick

(a) Residence. No. .... St. .... Ward. ....  
(Usual place of abode) (If nonresident give city or town and State)

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

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S  
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.

**8. OCCUPATION OF DECEASED**

- (a) Trade, profession, or particular kind of work
- (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)

10. NAME OF FATHER

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 (Address)

15. FILED 3-20-20 1920 Ed. Robert Prater

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/25 1920

17. I HEREBY CERTIFY That I attended deceased from ..... 19....., 19..... that I last saw him ..... alive on ..... 19....., and that death occurred, on the date stated above, of .....

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Perforated Abdomen  
3rd degree  
Was caused by pulling hot coffee off  
the stove while in mother's arms

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) ..... M. D. , 19 (Address)

\*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

20. UNDERTAKER ADDRESS

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-9722