

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

Do not use this space.

20314

1. PLACE OF DEATH

County Platte Registration District No. 693
Township _____ Primary Registration District No. 4413
City Edgerton No. _____ St. _____ Ward _____

File No. _____
Registered No. _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

Mary Elizabeth Guinn

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec-15-1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
71 6 9

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housekeeper
(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) Platte Co Mo.

10. NAME OF FATHER Elisha Guinn

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

12. MAIDEN NAME OF MOTHER Agnis Mason

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

14. INFORMANT J. H. Guinn
(Address) Edgerton Mo.

15. FILED 7/10, 1930 J. H. Rollins
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 24 1930

17. I HEREBY CERTIFY, That I attended deceased from Apr 29 1930 to June 23 1930 that I last saw her alive on June 23 1930, and that death occurred, on the date stated above, at 2:30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia (Interstitial)
82 D
7/19/30
(duration) yrs. mos. da. 3 da.

CONTRIBUTORY (SECONDARY)

Paralysis (duration) 1 yrs. mos. da.

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 findings.

(Signed) R. L. Abolt D.O. M.D.

, 19 (Address) Edgerton Mo.

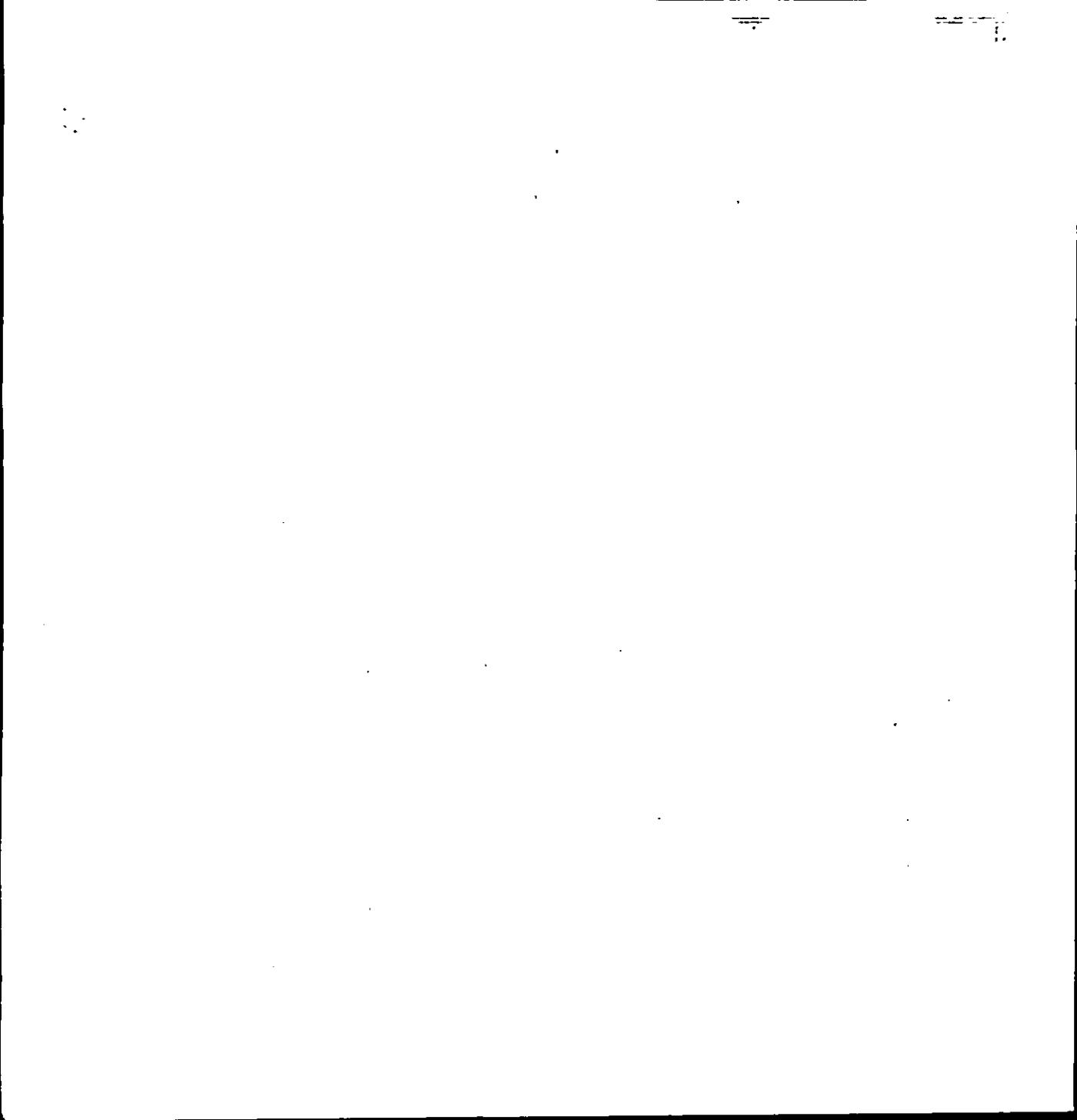
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

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

Union Hill Cem. June 25-1930

20. UNDERTAKER ADDRESS

J. H. Rollins Edgerton Mo.



**MISSOURI STATE BOARD OF HEALTH
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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Platte Registration District No. 693 File No. _____
 Township _____ Primary Registration District No. 4415 Registered No. _____
 City Edgerton St. _____ Ward _____

2. FULL NAME Mary Elizabeth Swin
 (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) _____

PARENTS

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 7/10/1930 A. H. Rollins REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 24 1930

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, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Paralysis
 _____ (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (PRIMARY) Paralysis (Venereal)
 (SECONDARY) plague (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
	19____
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

S-20314

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