NOV 20 1937

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

Do not use this space.

1. PLACE OF DEATH
County Newton
Township Franklin
City Stella (No. ..... St. ..... Ward)

Registration District No. 608
Primary Registration District No. 5807

File No. 38344
Registered No. 31

2. FULL NAME Nemo Guinn

(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: M
4. COLOR OR RACE: W
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) Sept 24-1920

7. AGE: Years 17 | Months 0 | Days 9 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Young Man
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. at home farm
10. Date deceased last worked at this occupation (month and year) .....
11. Total time (years) spent in this occupation parents

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

FATHER

13. NAME Dan Guinn
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

MOTHER

15. MAIDEN NAME Effie Reed
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT Dan Guinn (ADDRESS) Anderson R3

18. BURIAL, CREMATION, OR REMOVAL
PLACE Owsley Cmty DATE Sept 24 1937

19. UNDERTAKER Chas W. Williams (ADDRESS) Goodman Mo

20. FILED Nov. 9 1937 Ada Collings Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 23 1937

22. I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1937, to Sept 23, 1937
I last saw him alive on Sept. 23, 1937 Death is said to have occurred on the date stated above, at 8 9 m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Typhoid fever	

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) C. Cordwell, M. D.
(Address) Stella 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.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

38344
Do not use this space.

1. PLACE OF DEATH
(a) County Newton Registration District No. 608
(b) Township Franklin Primary Registration District No. 5807 Registered No.
(c) City (d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Nemo Guinn
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m
4. COLOR OR RACE w
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) S

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.
17	0	19	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. young man
9. Industry or business in which work was done, as saw mill, bank, etc. at home with parents
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation all life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Nov 9, 1937 Ada Collings
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 23, 1937

22. I HEREBY CERTIFY, That I attended deceased from ....19.... to ....19....
I last saw h.... alive on ....19.... Death is said to have occurred on the date stated above, at ....m.
The principal cause of death and related causes of importance were as follows:

	Date of onset

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury ....19....
Where did injury occur?
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) ....., M. D.
(Address)

SUPPLEMENTARY

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