

82

JUN 29 1940

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

19251

Do not use this space.

1. PLACE OF DEATH *Pike* 2
(a) County *Pike* Registration District No. *685-*
(b) Township *CLARKUMET* Primary Registration District No. *4409*
(c) City *CLARKSVILLE* (d) Street No. _____
(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 *Jacob George Claude Guile*
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *infant*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Dec 25, 1939*
7. AGE YEARS _____ MONTHS *4* DAYS *30* If LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *infant*
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) *Clarksville mo*
(STATE OR COUNTRY)

FATHER 13. NAME *Arthur Guile*
14. BIRTHPLACE (CITY OR TOWN) *Clinton Iowa*
(STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME *Madelaine Cooley*
16. BIRTHPLACE (CITY OR TOWN) *Rock Island Ill*
(STATE OR COUNTRY)

17. INFORMANT *Mrs. Arthur Guile*
(ADDRESS) *Clarksville mo*

18. BURIAL, CREMATION, OR REMOVAL
PLACE *Harvey La* DATE *May 26*

19. FUNERAL DIRECTOR *W. W. ...*
(ADDRESS) *Clarksville Mo*

20. FILED *6/7* 19 *40* *W. W. ...*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *5-24* 19 *40*

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:

This baby was found dead in bed apparently died from suffocation. 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) *Porter ...*

(Address) *Boulton ...*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

50M-7-20-37 I X12004

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.

RECEIVED

District Health Officer No. 10

District File Number 6-40-1237

Date Filed JUN 12 1940

STATEMENT BY LICENSED EMBALMER

Harvey L. Carroll

Licensed Embalmer No. 2439

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

Cavity work only

Harvey L. Carroll

L. E.

No. _____ or by _____
working under my personal supervision.

Registered Apprentice No. _____

Signed *Harvey L. Carroll*

Licensed Embalmer No. 2439

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)