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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2289

Registration District No. 205

Primary Registration District No. 5283

Registrar's No. _____

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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County Clinton
 (b) City or town R.F.D. #2 Atchison Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether _____)
 In this community _____
years, months or days)

3. (a) PRINT FULL NAME Hal Burton Guinn
 3. (b) If veteran, name war ✓
 3. (c) Social Security No. ✓

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased January 29 1885
(Month) (Day) (Year)

8. AGE: Years 62 Months 11 Days 4 If less than one day _____ hr. _____ min.

9. Birthplace Buchanan county Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business _____

MOTHER FATHER
 { 12. Name Houston Guinn
 { 13. Birthplace Mo.
(City, town, or county) (State or foreign country)
 { 14. Maiden name Katherine MacMechan
 { 15. Birthplace Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Carl Guinn
 (b) Address Gower, Mo.

17. (a) Burial (b) Date thereof 1/5/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Allen Cemetery

18. (a) Signature of funeral director H.A. Sullivan
 (b) Address Gower, Mo.

19. (a) Jan. 4-1941 (b) Ms. J.C. Starks
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Clinton
 (c) City or town R.F.D. #2
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month January day 3
 year 1941 hour 09:30 minute _____ P.M.
 21. I hereby certify that I attended the deceased from Jan 24-1940
 _____, 1940, to Jan 3rd, 1941;

that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death Arterio Sclerosis / uremic coma

Due to _____
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____
 Of autopsy _____

PHYSICIAN

 Underline the cause to which death should be charged statistically.
 Duration years 3 days

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? Yes

While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature J.C. Starks (M. D. or other) ✓
 Address Gower, Mo. Date signed _____

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed H. A. Sullivan

Licensed Embalmer No. 1738

P. O. Address Gower, Mo.

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.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 2289

Registration District No. 205

Primary Registration District No. 2283

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Clinton

(b) City or town Atchison, T.P.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ (Specify whether _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Hal Burton Guinn

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. SEX M

5. COLOR OR RACE W

6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year _____

7. BIRTH DATE OF DECEASED: _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 65 Months 11 Days 4 If less than one day _____ hr. _____ min.

9. Birthplace: _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace: _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace: _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month Jan day 3 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death: Arteriosclerosis

premia coma

Due to _____

Due to Chronic nephritis

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (c) Means of injury _____

23. Signature J. L. Starks (M. D. or other) _____

Address _____ Mo Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

