

Registration District No. 946

Primary Registration District No. 6725

Registrar's No.

1. PLACE OF DEATH:

(a) County Wright
 (b) City or town Gravelking
 (If outside city or town limits, write "RURAL" and name of township)
 Name of hospital or institution None
 (If not in hospital or institution, write street number or location)
 Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days _____

8. (a) PRINT FULL NAME HUBB C. Guinn

9. (b) If veteran, name war _____ 8. (c) Social Security No. _____

Sex M 5. Color W race W 6. (a) Single, widowed, married, divorced Married

(b) Name of husband or wife Guinn 6. (c) Age of husband or wife if alive 64 years
 7. Birth date of deceased Mar 9 1917
 (Month) (Day) (Year)

8. AGE: Years 64 Months 1 Days 6 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____
 Name Porter Guinn
 Birthplace Tennessee
 (City, town, or county) (State or foreign country)

14. Maiden name Kathleen Hickey
 15. Birthplace Tennessee
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature William Guinn
 (b) Address Home Spring 977

17. (a) Interment (b) Date thereof Mar 16 1941
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Byrdial

18. (a) Signature of funeral director H. M. Warner
 (b) Address Home Spring

19. (a) 4/3/41 (b) [Signature]
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Wright
 (c) City or town Gravelking Rural
 (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 Mar. day 15
 year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from March 12-1941
 _____, 19____, to March 15, 19____,
 that I last saw him alive on March 12, 19____,
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute myocardial failure Duration _____
 Due to Chronic valvular heart disease (Mitral insufficiency & hypertrophy & dilatation)
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

Major findings: None
 Of operations _____
 Of autopsy None 92
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically

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) (e) Means of injury _____
 23. Signature [Signature] M. D. or other _____
 Address Manqua, MO. Date signed 3/24/41

N. B.—Every item of information should be carefully supplied. AGE should be stated in full years, months and days. CAUSE OF DEATH should be stated in full. It may be properly classified. PHYSICIANS should state their names and addresses.

RECEIVED

District Health Officer No. 6,

District File Number 641-994

Date Filed JUN 18 1941

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.....

Licensed Embalmer No.....

P. O. Address.....

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.