V. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 9011

FILED MAR 25 1943

Registration District No. 49 — Primary Registration District No. 1002 — Registrar's No. 1266

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town KC Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Home / 516 Tracy (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether In this community unknown years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 48

(c) City or town KC 5 8 (If outside city or town limits, write "RURAL")

(d) Street No. 516 Tracy (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME SARAH GUY CARSON

3. (b) If veteran, name war NO

3. (c) Social Security No. none

4. Sex FE

5. Color or race 3 NEGRO

6. (a) Single, widowed, married, divorced 2 WIDOWED

6. (b) Name of husband or wife unknown

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased Sept (Month) (Day) 1848 (Year)

8. AGE: Years 94 Months 7 Days [illegible] If less than one day ..... hr. ..... min.

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

10. Usual occupation unemployed

11. Industry or business

FATHER
12. Name John Guy
13. Birthplace Kentucky (City, town, or county) / (State or foreign country)

MOTHER
14. Maiden name Gane
15. Birthplace Kentucky (City, town, or county) / (State or foreign country)

16. (a) Informant Mr Guy

(b) Address Fort Wayne Ind.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-15-43 (Month) (Day) (Year)

(c) Place: burial or cremation Topeka Kans

18. (a) Signature of funeral director Flynn & Greensbert

(b) Address KC Mo

19. (a) 3/14/43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day March year 43 hour 6 minute 45 A.M.

21. I hereby certify that I attended the deceased from January 1943 to March 1943 that I last saw her alive on March 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Heart Disease — Duration 4 mo

Due to Increased arterial tension

Due to Chr. nephritis 131 B

Other conditions (Include pregnancy within 3 months of death) Pareuchymatous

Major findings: Of operations none

Of autopsy none

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? — (Specify type of place)

While at work? — (e) Means of injury

23. Signature J. Wells 0 (M. D. or other)

Address 1605 E 18 Sta Date signed 3-13-43

(Licensed Embalmer's Statement on Reverse Side)

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, fact should be so stated above.