No. 2
5-42
17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 14 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11685

Registration District No. 8-32381 Primary Registration District No. 4518 Registrar's No.

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

1. PLACE OF DEATH:
(a) County SULLIVAN
(b) City or town MILAN
(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 10 MONTHS years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County PUTNAM 86 1 2
(c) City or town UNIONVILLE
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME BARBARA ANN GUFFEY
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓

4. Sex FEMALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced 2 WIDOWED
6. (b) Name of husband or wife WILLIAM GUFFEY
6. (c) Age of husband or wife if alive 1 years
7. Birth date of deceased JUNE (Month) 1 (Day) 1864 (Year)

8. AGE: Years 78 Months 8 Days 7 If less than one day hr. min.

9. Birthplace DON'T KNOW (City, town, or county) VIRGINIA (State or foreign country)
10. Usual occupation AT HOME
11. Industry or business HOUSEWORK
MOTHER FATHER
12. Name JACOB ELVARD
13. Birthplace DON'T KNOW (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name CHRISTINA LAMB
15. Birthplace DON'T KNOW (City, town, or county) (State or foreign country)
16. (a) Informant SAM HAYES
(b) Address MILAN, MO
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB 10-1943 (Month) (Day) (Year)
(c) Place: burial or cremation UNIONVILLE CEMETERY
18. (a) Signature of funeral director COMSTOCK FUNERAL HOME
(b) Address UNIONVILLE MO By John N. Comstock
19. (a) FEB. 9-43 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEBRUARY day 8
year 1943 hour 4 minute 30 A.M.
21. I hereby certify that I attended the deceased from JAN. 27, 1943, to FEB 8, 1943, that I last saw her alive on FEB 7, 1943, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: CEREBRAL HEMORRHAGE	FEB 7
Due to: SENILITY	1942
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: NONE	
Of autopsy:	

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 Earl Simpson M.D. or Coroner
Address Milan Date signed 2-9-43

1190 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 4-43-714
Date Filed APR 13 1943

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 James W Comstock
Licensed Embalmer No. 4197
P. O. Address Unionville 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, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1168 V

Registration District No. 381 Primary Registration District No. 45 1 V Registrar's No.

1. PLACE OF DEATH:
(a) County Sullivan
(b) City or town Milan
(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 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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Barbara Ann Guffey
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced W

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

7. Birth date of deceased June (Month) 1 (Day) 1865 (Year)

8. AGE: Years 79 | Months 8 | Days | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) Feb 9-43 (Date received local registrar) (b) Mrs L A Gleam (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 8
year 1943 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	Duration
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.

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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

5-11685