

LED DEC 9 1943

Registration District No. 243

Primary Registration District No. 436f

Registrar's No. 29

1. PLACE OF DEATH:

(a) County Newton
(b) City or town Stella, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Cardwell Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days
(Specify whether
In this community 10 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County McDonald
(c) City or town Stella, Mo. Rt. No. 1
(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 Gertrude Guinn

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 Married

6. (b) Name of husband or wife Geo. Guinn 6. (c) Age of husband or wife if alive 7 years

7. Birth date of deceased April 5 1909
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>34</u>	<u>7</u>	<u>23</u>	hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name O. F. Littlefield

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

14. Maiden name Julia Ark.

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

16. (a) Informant O. F. Littlefield

(b) Address Locust Grove, Okla.

17. (a) Burial - Removal (b) Date thereof 11-30-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Aspe Cemetery

18. (a) Signature of funeral director Chas. W. Williams

(b) Address Goodman, Mo.

19. (a) 12-3-1943 (b) Alpha L. Hale Dyer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 28
year 1943 hour 6 pm minute _____ M.

21. I hereby certify that I attended the deceased from Nov. 22 1943 to Nov. 28 1943
that I last saw her alive on Nov. 28 1943
and that death occurred on the date and hour stated above.

Immediate cause of death

peritonitis
Due to gangrenous cystic
stomach
Due to _____

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations Gangrenous
Cystic tumor
Of autopsy _____

Duration

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 J. B. [unclear] (M. D. or other) _____
Address Stella, Mo. Date signed 11/29/43

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

MOTHER FATHER

RECEIVED 12-5-43
District Health Officer No. _____
District File Number 1243-223
Date Filed 12-7-43

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Dec.

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Newton
 (b) City or town Stella
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Cardwell Hosp.
(If not in hospital or institution, write street number & location)
 (d) Length of stay: In hospital or institution 7 da. (Specify whether
 In this community 10 yr. years, months or days)

3. (a) PRINT FULL NAME Gertrude Guinn
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced m
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 27 years

7. Birth date of deceased April 5
(Month) (Day) (Year)

8. AGE: Years 34 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind. (b) County McDonald
 (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov Day 28
 Year 1943 Hour _____ Minute _____ M.

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

Suppressed typhoid
 Due to small cyst in
right testis
 Other conditions twisted pedicle
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy 129

Duration _____
 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? _____ (c) Means of injury _____

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

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

SUPPLEMENTARY

38785