. S. No. 2
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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 23 1945

Registration District No. 149

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 12187

Registrar's No. 1684

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hospital #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 Hr. 5 Min. (Specify whether years, months or days)
In this community Three Years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson
(c) City or town: Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No.: 1415 E. 17th St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: EFFIE GUY
3. (b) If veteran, name war: NO
3. (c) Social Security No. 495-24-8831
4. Sex: Female
5. Color or race: Negro
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Walter Guy
6. (c) Age of husband or wife if alive: 30 years
7. Birth date of deceased: June (Month) 29 (Day) 1915 (Year)
8. AGE: Years 29 Months 9 Days ~~28~~ 11 If less than one day hr. min.
9. Birthplace: Rosedale (City, town, or county) Kansas (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business:
FATHER
12. Name: Earl Ragland
13. Birthplace: (City, town, or county) unknown (State or foreign country)
MOTHER
14. Maiden name: La Verne Green
15. Birthplace: Kansas City (City, town, or county) Missouri (State or foreign country)
16. (a) Informant: Record Clerk
(b) Address: Gen. Hosp. #2
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-16-45 (Month) (Day) (Year)
(c) Place: burial or cremation: Lincoln Cemetery
18. (a) Signature of funeral director: West, Appleby & Jones
(b) Address: 1905 Vine St.
19. (a) 4-14-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10 year 1945 hour 9:15 minute P M.
21. I hereby certify that I attended the deceased from April 10 3:10 P. M. 45, 19__, to 9:15 Pm. 45, 19__; that I last saw her alive on Apr. 10, 9:15 pm. 45, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: PLACENTA Precenta Praevia with Massive Hemorrhage and Shock	
Due to: (DELIVERED)	
Due to:	
Other conditions (Include pregnancy within 3 months of death): 146a	

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: Gen. Hosp. #2 - 601 E. 22 Date signed 4-13-45

(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 C. H. West

Licensed Embalmer No. 2710

P. O. Address Kansas City, 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.