S. No. 2
M—8-43
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 MAY 10 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13749

Registration District No. 170 Primary Registration District No. 3033 Registrar's No.

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Lebanon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wallace Memorial Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1-week (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Camden
(c) City or town Branch 15
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME John Henry Guest
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Mary
6. (c) Age of husband or wife if alive years
7. Birth date of deceased unknown 1873 (Month) (Day) (Year)

8. AGE: Years 73 Months Days If less than one day hr. min.

9. Birthplace Camden Co (City, town, or county) MO (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER
12. Name Jim Guest
13. Birthplace unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Margaret Whitwell
15. Birthplace unknown (City, town, or county) (State or foreign country)
16. (a) Informant J. T. Guest
(b) Address Lebanon 114 N Jackson
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-1-45 (Month) (Day) (Year)
(c) Place: burial or cremation Pleasant Grove
18. (a) Signature of funeral director L B Jones
(b) Address Buffalo Mo
19. (a) May-1-45 (Date received local registrar) (b) Grace Roper (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month March day 30 year 1945 hour 1:00 minute P M.
21. I hereby certify that I attended the deceased from 3-23-, 1945, to 3-30-, 1945 that I last saw him alive on 3-30, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cornary ~~Thrombosis~~ Embolis	30 min.
Due to	
Due to	
Other conditions Prostitis (Include pregnancy within 3 months of death)	
Major findings: Of operations 9 hr	
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 R. E. Harrell (M. D. or other) MD
Address Lebanon Mo Date signed 3-30-45

1090

(Licensed Embalmer's Statement on Reverse Side)

Received
Laclede County Health Unit
File No. 4-45-39
Date Filed 5/8/45

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 Leonard B. Jones

Licensed Embalmer No. 2508

P. O. Address Buffalo 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.