

FILED OCT 24 1945 STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1053

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St Joseph
(c) Name of hospital or institution: 702 North 4
(d) Length of stay: In hospital or institution over 40 yrs
In this community over 40 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Buchanan
(c) City or town St Joseph
(d) Street No. 702 North 4
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME WILLIAM-S-GUY

3. (b) If veteran, name war NO 3. (c) Social Security No. NO

4. Sex Male 5. Color or race Wht 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased March 20 1866

8. AGE: Years 79 Months 6 Days 7

9. Birthplace Bonifant Co Mo

10. Usual occupation Retired Painter & Paper Hanger

11. Industry or business Paper Hanger

12. Name John R. Guy

13. Birthplace Ky

14. Maiden name Mary P. Rowland

15. Birthplace Ky

16. (a) Informant Ray O. Guy

(b) Address 1516 7th Ave

17. (a) (b) Date thereof 9-29-45

(c) Place: burial or cremation St Joseph City, Missouri

18. (a) Signature of funeral director St. Joseph Funeral Home

(b) Address St Joseph

19. (a) 10-4-45 (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 27 year 1945 hour 8:45 minute a.m.

21. I hereby certify that I attended the deceased from 9/24 1945 to 9/27 1945 that I last saw him alive on 9/26 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Aortic Aneurysm, Ruptured, Cystic Enlarged, Prosthetic Standy

Due to: Acl

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

Major findings: Of operations: Of autopsy: No

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? (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: W. Stamey (M. D. or other)

Address: 2639 St. Joseph Ave Date signed 9/28/45

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 John Roy Stoney
Licensed Embalmer No. 2435
P. O. Address St. Joseph 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.