

U.S. No. 2
OM-5-43
v. 5-17-39
I X38671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27862
Registrar's No. 69

FILED SEP 4 1946

Registration District No. 245 Primary Registration District No. 3047

1. PLACE OF DEATH:

(a) County Newton

(b) City or town Neosho, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Sales Memorial Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 Hrs.
(Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County McDonald

(c) City or town Anderson R.R. #3
(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 Donald Lee Guinn

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 13
year 1946 hour 3 minute 0A. M.

21. I hereby certify that I attended the deceased from 12 AUG 1946, 19____, to 13 AUG, 1946;

that I last saw him alive on 13 AUG, 1946;
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race white

6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased Jan. 17 1931
(Month) (Day) (Year)

Immediate cause of death ACUTE BRAIN INJURY Duration 10 Hours

Due to _____

Due to _____

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

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

15	6	28	hr. min.
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9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

12. Name Daniel Guinn

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

14. Maiden name Ellie Reed

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

16. (a) Informant Oma Depreist

(b) Address Anderson R.R. #3 Mo.

17. (a) Burial (b) Date thereof 8-15-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial of ##### Owsley Cemetery

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

(b) Address Goodman, Mo.

19. (a) 8-31-46 (b) Melvin C. Bowman
(Date received local registrar) (Registrar's signature)

Major findings: Of operations 1700-8

Of autopsy 22

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) ACCIDENT

(b) Date of occurrence 12 AUG 1946

(c) Where did injury occur? McDONALD Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Yes
Highway 71

While at work? _____ (Specify type of place)

(e) Means of injury CAR COLLISION

Signature R. J. Taylor M.D. (M. D. or other)

Address 13 W. Hickory Neosho Mo. Date signed 33 Aug 46

223 (Licensed Embalmer's Statement on Reverse Side)
Collision with other Motor Veh.

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

2332

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.