

FILED SEP 29 1947

State File No. _____

3983

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. _____

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 NO. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 22 DAYS
(Specify whether _____)
In this community 10 YRS.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON **48**
(c) City or town KANSAS CITY **3**
(If outside city or town limits, write "RURAL.") **8**
(d) Street No. 2445 TRACY
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME WILLIE GUINN

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex FEMALE 5. Color or race NEGRO
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased MAY 10, 1809
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>38</u>	<u>4</u>	<u>6</u>	_____hr. _____min.

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

10. Usual occupation HOUSEWORK

11. Industry or business _____

12. Name JAMES GUINN
13. Birthplace TEXAS
(City, town, or county) (State or foreign country)
14. Maiden name LENA GREEN
15. Birthplace TEXAS
(City, town, or county) (State or foreign country)

16. (a) Informant HENRY GUINN (BROTHER)
(b) Address 2445 TRACY

17. (a) Funclon (b) Date thereof 9/20/47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Funclon

18. (a) Signature of funeral director William R. ...
(b) Address 2304 Vine St

19. (a) 9-19-47 (b) Steldine Holme
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPTEMBER day 16,
year 1947 hour 1: minute 40 P. M.

21. I hereby certify that I attended the deceased from AUGUST 25,
1947 to SEPTEMBER 16, 19 47
that I last saw h. ER alive on SEPTEMBER 16, 19 47
and that death occurred on the date and hour stated above.

Immediate cause of death CARDIAC FAILURE
due to Chronic nephrosis
etiology unknown
Due to CHRONIC NEPHROSIS

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

Major findings:
Of operations _____
Of autopsy 13/15
Underline the cause of 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) Manner of injury _____

23. Signature [Signature] (M. D. or other) M.D.
Address GENERAL HOSPITAL NO. 2 Date signed 9/17/47

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

MOTHER FATHER

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 B. L. Graham
Licensed Embalmer No. 2548
P. O. Address 2304 Vine St.

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.