

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22610**

FILED AUG 8 1949

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BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>CARROLL</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>St Joseph</u>		c. LENGTH OF STAY (In this place) <u>4 mo 25 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>CARROLLTON</u>		d. STREET ADDRESS (If rural, give location) <u>Do Not Know</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>State Hospital no 2 D</u>				d. STREET ADDRESS (If rural, give location) <u>Do Not Know</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Guy</u>			b. (Middle) _____		c. (Last) <u>Hill</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 13 1949</u>		
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>unknown</u>		9. AGE (In years last birthday) <u>73?</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>not known</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>unknown</u>			13b. MOTHER'S MAIDEN NAME <u>unknown</u>			14. NAME OF HUSBAND OR WIFE <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT'S SIGNATURE OR NAME, ADDRESS <u>MRS. LUCY HINCK HARVEYVILLE KANSAS.</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u> ANTECEDENT CAUSES DUE TO (b) <u>arterio-sclerosis</u> DUE TO (c) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH <u>4221</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>July 1</u> , 1949, to <u>July 13</u> , 1949, that I last saw the deceased alive on <u>July 13</u> , 1949, and that death occurred at <u>5:30 P. m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Forrest Thomas M.D.</u>				23b. ADDRESS <u>St Joseph Mo. op State Hosp no 7/14-49</u>			23c. DATE SIGNED		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>July 14, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Wilmington</u>		24d. LOCATION (City, town, or county) (State) <u>Wilmington, Kansas</u>			
DATE REC'D BY LOCAL REG. <u>Aug. 1, 1949</u>		REGISTRAR'S SIGNATURE <u>S. B. Jenkins</u>		382		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Stamey Funeral Home St Joseph, Mo.</u>			

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Charles M. Hanna

Signed _____
Student Embalmer

Licensed Embalmer No. 4487

P. O. Address St. Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.