

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13318

State File No.

74287
APR 20 1953

BIRTH NO. REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 441

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Holt	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Forest City 1440	
c. LENGTH OF STAY (in this place) 5 days		d. STREET ADDRESS (If rural, give location) /	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Methodist Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Larry b. (Middle) Dale c. (Last) Guyer			4. DATE OF DEATH April 11 1953		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant	8. DATE OF BIRTH Nov 8 1952	9. AGE (In years last birthday) 5	10. MONTH 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Fairfax, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Cleo Guyer	13b. MOTHER'S MAIDEN NAME Katherine Whipple	14. NAME OF HUSBAND OR WIFE none
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Infant	16. SOCIAL SECURITY NO. Infant	17. INFORMANT'S SIGNATURE OR NAME Cleo Guyer	ADDRESS Forest City, Mo.
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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		INTERVAL BETWEEN ONSET AND DEATH 5 hrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Hydrocephalus, meningitis		
	ANTECEDENT CAUSES DUE TO (b) myelocystic Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) Multiple congenital deformities		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 752X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from 4/6 1953, to 4/11 1953, that I last saw the deceased alive on 4/11, 1953 and that death occurred at 8:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE Charles J. Shewell M.D.	23b. ADDRESS 902 Grand St.	23c. DATE SIGNED 4/14/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE April 12-53	24c. NAME OF CEMETERY OR CREMATORY Forest City	24d. LOCATION (City, town, or county) (State) Forest City Missouri
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DATE REC'D BY LOCAL REG. APR 15, 1953	REGISTRAR'S SIGNATURE Katherine M. Allison	25. FUNERAL DIRECTOR'S SIGNATURE Wm. Rich Lawrence	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

STATEMENT BY LICENSED EMBALMER

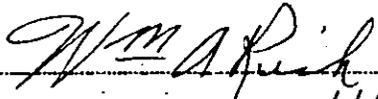
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____



Licensed Embalmer No. 4728

P. O. Address Savannah, Ga.

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.