

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **13460**

FILED MAY 11 1953

BIRTH NO. _____ REG. DIST. NO. **47** PRIMARY REG. DIST. NO. **3008** Registrar's No. **170**

1. PLACE OF DEATH a. COUNTY CALLOWAY 0143 b. CITY OR TOWN FULTON MISSOURI c. LENGTH OF STAY (in this place) 4 yrs d. FULL NAME OF HOSPITAL OR INSTITUTION STATE HOSPITAL NO 1.		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY SCOTLAND 6440 c. CITY OR TOWN MEMPHIS d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) MYRA a. (First) b. (Middle) c. (Last) GUINN		4. DATE OF DEATH (Month) (Day) (Year) MAY - 2 nd 53	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH jan- 30- 1879
9. AGE (In years last birthday) 74 if UNDER 1 YEAR 3 Months 8 Days if UNDER 24 Hrs. Hours Min.		11. BIRTHPLACE (City and State or Foreign Country) Memphis Mo 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Milliner		10b. KIND OF BUSINESS OR INDUSTRY milinery	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME DAVID - GUINN	
13b. MOTHER'S MAIDEN NAME LOUISE MCCANDLESS		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT'S SIGNATURE OR NAME ADDRESS HOSPITAL RECORDS FULTON MO			
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) Acute obstructive Exudative Bronchitis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Atelectasis Inition DUE TO (c) Polmonary Tuberculosis AND Anemia.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 002X	
20. AUTOPSY? YES <input checked="" 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>JUNE 1 52</u> 19 <u>52</u> , to <u>May 4</u> 19 <u>53</u> , that I last saw the deceased alive on <u>May 2</u> 19 <u>53</u> , and that death occurred at <u>9:2</u> a.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title)		23b. ADDRESS	
_____ Fulton Mo		_____ May 7-1953	
24a. BURIAL, CREMATION, OR REMOVAL (Specify)		24b. DATE	
_____ May 6, 1953		24c. NAME OF CEMETERY OR CREMATORY	
_____ Memphis		24d. LOCATION (City, town, or county) (State)	
_____ Memphis Mo		_____	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE	
May 4-1953		_____ 425	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
_____ Wallace Funeral Home		_____ Fulton Mo	

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

0.300
0.48

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

Signature of Student Embalmer

Signed *Alvise C. Browning*

Licensed Embalmer No. *272*

P. O. Address *Dutton*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.