

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5791

FILED JAN 5 1955

BIRTH NO. REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (in this place) 3 yrs.	c. CITY OR TOWN Kansas City
d. FULL NAME OF HOSPITAL OR INSTITUTION 2305 Askew		STREET ADDRESS (If rural, give location) 2305 Askew	
3. NAME OF DECEASED (Type or Print) a. (First) Rev. William		b. (Middle) E.	c. (Last) Guy
4. DATE OF DEATH (Month) (Day) (Year) Dec. 17, 1954		5. SEX Male	
6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 24, 1874	9. AGE (In years last birthday) 80
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Shelbyville, Tenn.	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME George W. Guy		13b. MOTHER'S MAIDEN NAME Virginia Evergreen	14. NAME OF HUSBAND OR WIFE Dellie E. Guy
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 William N. Guy 804 N. Center St.	
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, assthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION Bloomington, Mo. ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Congestive Heart Failure Disease		DUE TO (b) Hypertensive Type of Heart/	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) Chronic Nephritis		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		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 June , 1954, to 12/17/ , 1954, that I last saw the deceased alive on 12/17/ , 1954 and that death occurred at 4:20A m., from the causes and on the date stated above.			
23a. SIGNATURE George H. Craft, M.D.		23b. ADDRESS 2204 East 18th Street,	23c. DATE SIGNED 12/18/54
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE Dec. 19, 1954	24c. NAME OF CEMETERY OR CREMATORY Springfield, Ill.	24d. LOCATION (City, town, or county) (State) Springfield, Illinois
DATE REC'D BY LOCAL REG. 12-18-54	REGISTRAR'S SIGNATURE Neve Marshall	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Watkins Bros. Funeral Home 18th & Benton	

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

Dr. Craft

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 *Bruce P. Watkins*

Licensed Embalmer No. *450*

P. O. Address *18th Ave*

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.