

FILED DEC 30 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40596  
State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 5352

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL, and give township) OR <b>Kansas City</b>	c. LENGTH OF STAY (In this place) <b>21 yrs.</b>	c. CITY OR TOWN <b>Kansas City</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4507 East 19th. Street</b>		STREET ADDRESS (If rural, give location) <b>4507 East 19th Street 3238</b>	

3. NAME OF DECEASED (Type or Print) <b>John</b>	a. (First)	b. (Middle) <b>C.</b>	c. (Last) <b>Guyer</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Dec. 8, 1955</b>
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Feb. 2, 1916</b>	9. AGE (In years last birthday) <b>39</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>T.W. A.</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Plattsburg, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>William Guyer</b>	13b. MOTHER'S MAIDEN NAME <b>Margaret Bowman</b>	14. NAME OF HUSBAND OR WIFE <b>Marjorie Guyer</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY (If yes, give war or dates of service) <b>486-10-0833</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Marjorie Guyer</b>	ADDRESS <b>4507 E. 19th. K.C., Mo</b>
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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, assthenia, etc. It means the disease, injury, or complication which caused death.	-I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH  <b>8976X</b>
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____			
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"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Suicide</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Kansas City Jackson Mo</b>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>12-8-55</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>Self Inflicted</b>

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23. SIGNATURE <b>Hugh H. Owens</b>	(Degree or title) <b>Cornet</b>	23b. ADDRESS <b>1034 Rialto Bldg</b>	23c. DATE SIGNED <b>12-9-55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Dec. 10, 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>White Chapel</b>	24d. LOCATION (City, town, or county) (State) <b>Kansas City N., Missouri</b>
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DATE REC'D BY LOCAL REG. <b>12-9-55</b>	REGISTRAR'S SIGNATURE <b>Wm Marshall</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Earp &amp; Sons</b>	ADDRESS <b>4139 Truman Rd. K.C., Mo.</b>
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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.....  
Signature of Student Embalmer

Signed.....

*James W. Camp*  
Licensed Embalmer No. *46*  
P. O. Address *W.C., M.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.