

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038955

STATE FILE NUMBER
1265

FILED DEC 1 1958

Registration District No. 042 Primary Registration District No. 1000

Registrar's No. 1265

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|---|-----------------------------------|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Buchanan | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Joseph 0117 0 | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 218 So. 10th St. | | Length of stay in 1b 14 yrs. | d. STREET ADDRESS 922 No. 3rd St. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) JESSIE JESSIE ALLEN JESSIE GUYER | | | 4. DATE OF DEATH Nov. 24, 1958 | | |
| 5. SEX Male 0 | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Sept. 27, 1901 | 9. AGE (In years last birthday) 57 yrs. | 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) Railroad employe | | 10b. KIND OF BUSINESS OR INDUSTRY Union Pacific | 11. BIRTHPLACE (City and state or country) Forbes, Missouri | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13a. FATHER'S NAME John Guyer | | 13b. MOTHER'S MAIDEN NAME Dora Beasley | | 14. NAME OF HUSBAND OR WIFE None | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) No. | | 16. SOCIAL SECURITY NO. 500-07-6518 | 17. INFORMANT Address Mrs. Betty Madlin, Parkville, Mo. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitral Insufficiency | | | | | INTERVAL BETWEEN ONSET AND DEATH Unk. |
| Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last. DUE TO (b) Broken Compensation | | | | | Unk. |
| DUE TO (c) | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 410X | | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | ITEM 3 CORRECTED BY AFFIDAVIT OF Informant 10-28-59 See | | | |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | | |
| 21. I attended the deceased from 3/8/57 , to 11/24/58 and last saw ^{her} him alive on 11/23/58 Death occurred at 6:15 A. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE D. B. Melunex M.D. (Degree or title) | | 22b. ADDRESS Social Welfare Bldg 10th & Olive, St. Joseph, Mo. | | 22c. DATE SIGNED 11/25/58 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Nov. 26, 1958 | 23c. NAME OF CEMETERY OR CREMATORY Highland Cemetery | | 23d. LOCATION (City, town, or county) Oregon (State) Missouri | |
| 24. FUNERAL DIRECTOR Horne Funeral Home (98) | | ADDRESS St. Joseph, Mo. | 25. DATE RECD. BY LOCAL REG. Nov. 26, 1958 | 26. REGISTRAR'S SIGNATURE Mrs. Clark Goodill | |

All diseases in Part I must be causally related. No symptoms will be listed. No conditions contributory to death in Part II. No symptoms will be listed.

MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. S. E. Melunex

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 *Charles E. Bennett*

Licensed Embalmer No. *4677*

P. O. Address *St. Joseph, Mo.*

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.