

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 16 1960

5-5 -60-030187

STATE FILE NUMBER

Registration District No. 120 Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

INDEXED

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Gentry</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Gentry</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Athens Township</b>		Length of stay in 1b <b>2yers.</b>		c. CITY OR TOWN <b>Albany</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Plainview Rest Home</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) _____		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Tillman</b> Middle _____ Last <b>Guess</b>				<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>7,</b> Year <b>1960</b>									
<b>5. SEX</b> <b>male</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>July 8 1922</b>		<b>9. AGE (last birthday)</b> <b>88</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>farming &amp; hardware bus.</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>agriculture</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Worth Co., Missouri</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.</b>					
<b>13a. FATHER'S NAME</b> <b>Peter Richard Guess</b>				<b>13b. MOTHER'S MAIDEN NAME</b> <b>Susan (unknown)</b>				<b>14. NAME OF HUSBAND OR WIFE</b> <b>Lily E. Grace Guess</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>				<b>16. SOCIAL SECURITY NO.</b> _____		<b>17. INFORMANT</b> Address <b>Mr. Wayne Guess, Albany, Mo.</b>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer stomach or gall bladder.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>also myocarditis</b> DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b>  <b>10 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____									
<b>20c. TIME OF INJURY</b> Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>											
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____				<b>20f. CITY, TOWN, OR LOCATION</b> <b>Albany</b>		<b>COUNTY</b> <b>Gentry</b>		<b>STATE</b> <b>Mo.</b>					
<b>21. I attended the deceased from</b> <b>1950</b> to <b>8-7-60</b> and last saw him alive on <b>8-7-60</b> Death occurred at <b>3:15 P.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
<b>22a. SIGNATURE</b> (Degree or title) <b>Frank A. Rose, M.D.</b>					<b>22b. ADDRESS</b> <b>Albany, Mo.</b>					<b>22c. DATE SIGNED</b> <b>8-8-60</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>burial</b>		<b>23b. DATE</b> <b>Aug. 10, 1960</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Lone Star</b>			<b>23d. LOCATION</b> (City, town, or county) (State) <b>Lone Star, Missouri</b>						
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Brooks-Cochell Funeral Home, Albany, Mo.</b>					<b>25. DATE RECD. BY LOCAL REG.</b> <b>8-8-60</b>			<b>26. REGISTRAR'S SIGNATURE</b> <b>Mrs. L. W. Bare</b>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by me \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Donald E. Coakley

Licensed Embalmer No. 4868

P. O. Address Albany, 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.