

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

14450

1. PLACE OF DEATH

County Callaway Registration District No. 102
Township 2 Primary Registration District No. 4062
City Arxuan (No.) St. Ward

File No.
Registered No. 88

2. FULL NAME

Jack Guest
(a) Residence, No. Franklin Ave St. Rural Ward

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male Negro 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Pinkney Guest
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 27 1891
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. about 48 11 00

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. farm hand
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

13. NAME Walter Guest

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

15. MAIDEN NAME Essie Kane

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Essie Kane, 322 W. Franklin Ave

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. UNDERTAKER (ADDRESS) Ray Holt, 1111 S. Main St, Fulton Mo

20. FILED April 27 1940 H. B. Nichols Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 27 1940

22. I HEREBY CERTIFY, That I attended deceased from April 24 1940 to April 27 1940. I last saw him alive on April 27 1940. Death is said to have occurred on the date stated above, at 10:45 a.m.
The principal cause of death and related causes of importance were as follows:

Tubercular Pneumonia
Date of onset

Other contributory causes of importance:

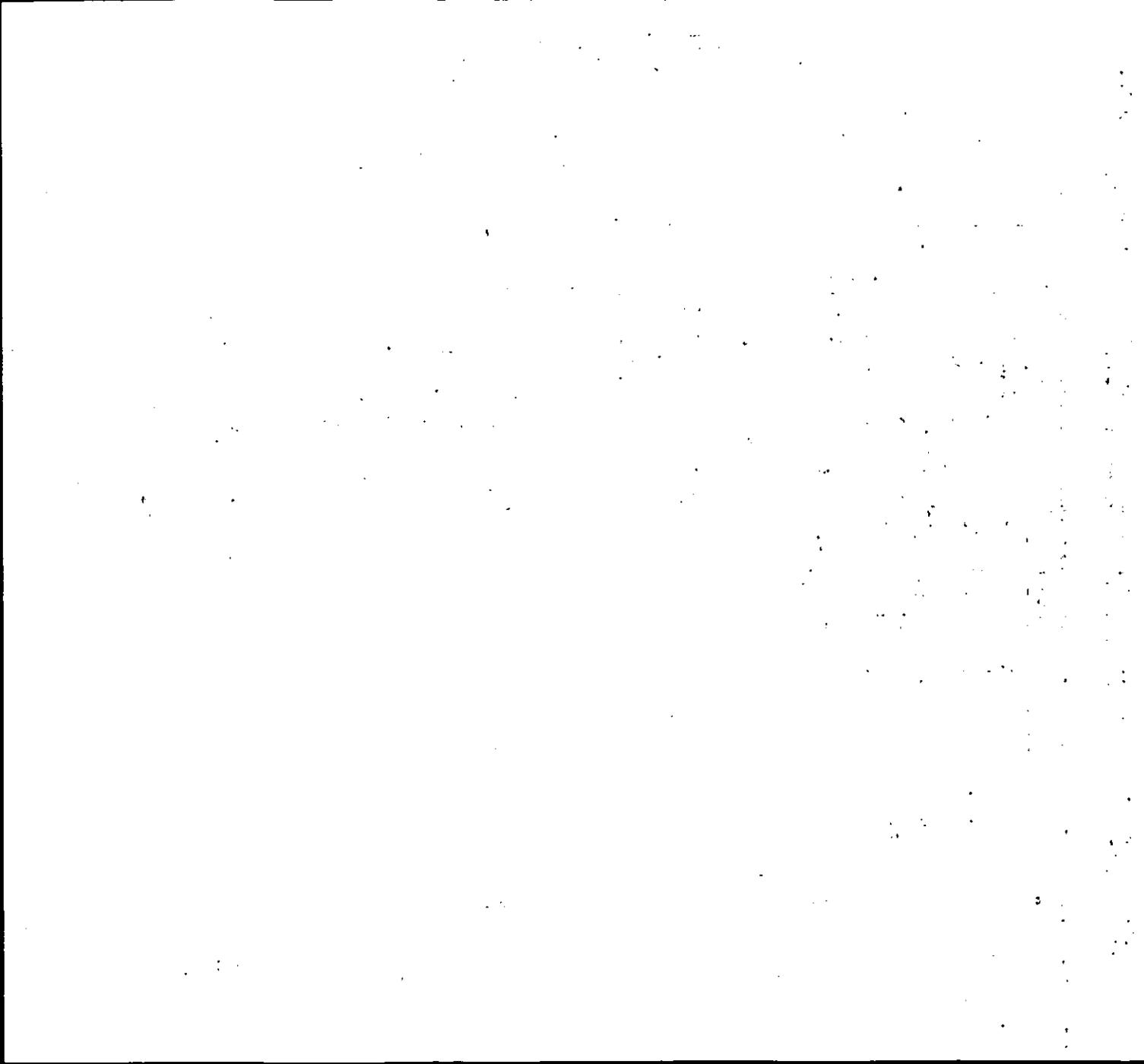
Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? Yes
If so, specify
(Signed) H. B. Nichols, M. D.
(Address) 1111 S. Main St, Fulton Mo



MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14459

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 102

Primary Registration District No. 4062

Registrar's No.

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

BAILENA MOORE

1. PLACE OF DEATH:

(a) County Calloway

(b) City or town Amvase
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ (Specify whether _____)

years, months or days

3. (a) PRINT FULL NAME Jack Grent

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color or race negr 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
48	11		h. min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) Burial (b) Date thereof April 28-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Apr 27 1946 (b) E.B. Nichols
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Calloway

(c) City or town Fulton "Rural"
(If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 27
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____, to _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____ (Specify type of place) (e) Means of injury _____

23. Signature C.B. Nichol (M. D. or other)

Address Amvase Mo. Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

S-14459