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No. 2
9-4-41
5-17-39
1 x294

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

FILED OCT 11 1943
Registration District No. 278

Primary Registration District No. 3054

Registrar's No.

1. PLACE OF DEATH:

(a) County Pike

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

(c) Name of hospital or institution: Pike County Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9/7/43 to 9/13/43
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County St Louis

(c) City or town ST. LOUIS MISSOURI
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? No (Yes or No)
If yes, name country /

3. (a) PRINT FULL NAME JULIA MAYES GUINN

(b) If veteran, name war No

(c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 13
year 1943 hour 1 minute 58 A.M.

21. I hereby certify that I attended the deceased from 9-12-43 to 9-13-43
that I last saw her alive on 9-12-43 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

6. (a) Single widowed married, divorced Widowed

6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive 12 - 2 - 1867 years (Month) (Day) (Year)

Immediate cause of death Cerebral hemorrhage

Due to Arterio-sclerosis

Other conditions (Include pregnancy within 3 months of death) None

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>9</u>	<u>11</u>	hr. min.

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

10. Usual occupation House wife

11. Industry or business None

MOTHER FATHER

12. Name ELIGA MAYES

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

14. Maiden name ESSKANDA TURNER
(City, town, or county) (State or foreign country)

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

Major findings: None

Of operations None

Of autopsy None

PHYSICIAN None
Underline the cause to which death should be charged statistically.

16. (a) Informant MRS. FRANK PAUL GRAY

(b) Address ANNADA MO.

17. (a) BURIAL (b) Date thereof 9-15-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CLARKSVILLE-C.E.M.

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

(a) Accident, suicide, or homicide (specify) None

(b) Date of occurrence None

(c) Where did injury occur? None
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work (Specify type of place) (e) Means of injury None

23. Signature Clifton Miller (M. D. or other) None
Address Louisiana Mo Date signed 9/14/43

18. (a) Signature of funeral director Clifton Miller

(b) Address ELSBERRY MO.

19. (a) 9-14-43 (b) Clifton Miller
(Date received local registrar) (Registrar's signature)

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

1164

43

RECEIVED

District Health Officer No. 10

District File No. ~~10-43-1676~~
~~007-8-1943~~

Date Filed _____

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 Sept. 13-1943

Registered Apprentice No. 3364

working under my personal supervision.

Signed Clifton Miller

Licensed Embalmer No. 3364

P. O. Address Elsherry, 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 this body is not embalmed, fact should be so stated above.