

FILED FEB 8 1944

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 19

1. PLACE OF DEATH:  
(a) County Adair  
(b) City or town Kirksville  
(c) Name of hospital or institution: Community Nursing Home  
(d) Length of stay: In hospital or institution 11-15-43 to 1-6-44  
In this community 20 years

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO. (b) County Adair  
(c) City or town Kirksville  
(d) Street No. 110 So High St  
(e) Citizen of foreign country? No.

3. (a) PRINT FULL NAME Mrs. LAURA M. GUY  
3. (b) If veteran, name war. .... 3. (c) Social Security No. ....

4. Sex F 5. Color or race W. 6. (a) Single, widowed, married, divorced M  
6. (b) Name of husband or wife Chas J Guy 6. (c) Age of husband or wife if alive 85 years  
7. Birth date of deceased 85-18-1862

8. AGE: Years 81 Months 7 Days 19 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name David R. Morrison  
13. Birthplace Richmond Ohio  
14. Maiden name Angeline W. Hart  
15. Birthplace Unionburg Kentucky

16. (a) Informant Edward Morrison  
(b) Address Kirksville Mo

17. (a) Burial (b) Date thereof 1-9-44  
(c) Place: burial or cremation Memphis, Tenn

18. (a) Signature of funeral director Sumner St Paul  
(b) Address Kirksville Mo

19. (a) 1/19/44 (b) Dr. J. L. Wagner

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month January day fifth year 1944 hour Five minute 10 P.M.

21. I hereby certify that I attended the deceased from November 5 to January 6, 1944  
that I last saw her alive on January 6, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-pneumonia

Due to left ventricular failure

Due to heart debility

Other conditions None

Major findings: Of operations No operations

Of autopsy No 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? \_\_\_\_\_  
(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 2

23. Signature A. R. Schell  
Address Community Nursing Home Date signed 1/19/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1049

Kirksville, Mo.

RECEIVED

District Health Officer No. 10

District File Number 2-44-300

Date Filed FEB 5 1944

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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed W. B. Summers

Licensed Embalmer No. 2159

P. O. Address Turksville, 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.