

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **282**

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **1**

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, write RURAL and give OR TOWN St. Joseph)		c. CITY OR TOWN St. Joseph	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) Life		e. STREET ADDRESS (If rural, give location) 2146 S. 22nd St.	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Missouri Methodist Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) DOYLE	b. (Middle) DUANE	c. (Last) GUYER	4. DATE OF DEATH (Month) (Day) (Year) Jan. 1, 1956
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH Dec. 13, 1936	9. AGE (In years last birthday) 19	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maintenance trucks	10b. KIND OF BUSINESS OR INDUSTRY Transfer Co.	11. BIRTHPLACE (City and State or Foreign Country) St. Joseph, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Doyle W. Guyer	13b. MOTHER'S MAIDEN NAME Mary E. Dallenbach	14. NAME OF HUSBAND OR WIFE none
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 500-36-2532	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Della Dallenbach, 2146 S. 22nd St. St. Joseph, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 mo. 6 mo +
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Brain abscess		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Frontal sinusitis DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 5/3x			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 20 Dec 1955 to 31 Dec 1955, that I last saw the deceased alive on 31 Dec 1955, and that death occurred at 8:03P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Donald J. Stallard M.D.	23b. ADDRESS 902 Edmond St. St. Joseph	23c. DATE SIGNED 1/8/56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1/4/1956	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
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DATE REC'D BY LOCAL REG. Jan 5, 1956	REGISTRAR'S SIGNATURE Rocher M. Allison	485	25. FUNERAL DIRECTOR'S SIGNATURE Heston - Bowman	ADDRESS St. Joseph, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

No. 300
10.48

FILED JAN 9 1956

M. Stollard

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

^{P.C.}
Signed *Richard D. Collins*

Licensed Embalmer No. *4957*
319 So. 10th St
P. O. Address *H. Jay*

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.