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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED SEP 27 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 30726

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3854

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City 0 — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gen'l Hosp. #1 — Length of stay in 1b 10 YRS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson 3830
c. CITY OR TOWN Kansas City — Inside Limits Yes ☒ No ☐ 8
d. STREET ADDRESS (If outside, give location) 234 W. 62 — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Jack Middle C. Last Guydon
4. DATE OF DEATH Month 8 Day 30 Year 1956
5. SEX male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Aug. 20, 1881
9. AGE (In years last birthday) 75 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life) Machinist Retired 7 yrs
10b. KIND OF BUSINESS OR INDUSTRY Burlington RR.
11. BIRTHPLACE (City and state or country) Medina, Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Frank Guydon
14. MOTHER'S MAIDEN NAME Mary Frost
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) - - - - - -
16. SOCIAL SECURITY NO. 520-05-3360A
17. INFORMANT Mrs Verna Guydon Address 234 West 62nd Kansas City, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Bronchogenic carcinoma with metastases
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH 162X
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from August 26, 1956 to August 30, 1956 and last saw ~~her~~ him alive on Aug. 30, 1956
Death occurred at 7:01 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [signature] (Degree or title) M.D.
22b. ADDRESS 24th & Cherry
22c. DATE SIGNED 8-30-56

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
23b. DATE Sept. 1. 1956
23c. NAME OF ~~CEMETERY OR~~ CREMATORY D.W. Newcomer's Sons
23d. LOCATION (City, town, or county) Kansas City (State) Missouri
24. FUNERAL DIRECTOR D. W. Newcomer ADDRESS 1331 Brush Creek
25. DATE RECD. BY LOCAL REG. 9-3-56
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was eml

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..Robert Ray.....

Licensed Embalmer No..418.

P. O. Address K. C., M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.