

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

**43525**  
STATE FILE NUMBER

FILED JAN 13 1958

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1445

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1420 S. 10th St.</b>		Length of stay in 1b <b>60 years</b>	d. STREET ADDRESS (If outside, give location) <b>1420 S. 10th St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>LILLIE</b> Middle <b>MAY</b> Last <b>GUYOT</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>24</b> Year <b>1957</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 23, 1882</b>		9. AGE (In years last birthday) <b>75</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (City and state or country) <b>Buchanan County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Elias Kerns</b>		13b. MOTHER'S MAIDEN NAME <b>Amanda unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Frank Guyot</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Frank Guyot, 1420 S. 10th St. Joseph, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Internal Hemorrhage</b>				INTERVAL BETWEEN ONSET AND DEATH <b>one hour</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b): <b>Carcinoma of Liver + Stomach</b>				DUE TO (c): <b>Irritation, indigestion etc.</b>	
PART II... OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): <b>151X</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>151X</b>			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <b>12/2-57</b> to <b>12-24-57</b> and last saw her/him alive on <b>12-22-57</b> Death occurred at <b>9:45p.</b> m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>W. Heimer M.D.</b> (Degree or title)		22b. ADDRESS <b>423 Main</b>		22c. DATE SIGNED <b>12/27/57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>12/27/1957</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ashland Cemetery</b>	
		23d. LOCATION (City, town, or county) <b>St. Joseph, Mo.</b>			
24. FUNERAL DIRECTOR <b>Heaton-Bowman</b>		ADDRESS <b>St. Joseph, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Jan. 3, 1958</b>	
				26. REGISTRAR'S SIGNATURE <b>Mrs. Robert Fulton</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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

Signed *William Spalding* .....

Licensed Embalmer No. *4535* .....

P. O. Address *319 S. 11th St. W. Wash. D.C.* .....

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.