8 1926

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

32490

1. PLACE OF DEATH
County: Stoddard
Township: Duck Creek
City: Dexter Mo (No. ..... St. ..... Ward)

Registration District No. 840
Primary Registration District No. 6102

File No. .....
Registered No. 33

2. FULL NAME: G. S. McGuire

(a) Residence. No. ..... St. ..... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR): ? ? 1865

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
63	?	?	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Baker
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY): Missouri

PARENTS

10. NAME OF FATHER: Wm McGuire
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY): West Va.
12. MAIDEN NAME OF MOTHER: ?
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY): West Va.

14. INFORMANT: Minnie McGuire
(Address): Dexter Mo

15. FILED: Sept 26 1928 E L Hope
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept 15 1928

17. I HEREBY CERTIFY, That I ~~attended~~ viewed deceased from ...., 19....., to ...., 19.....
that I last saw h..... alive on ...., 19....., and that death occurred, on the date stated above, at about 8 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Alcoholism
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 663
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) C. O. Bugg Jr coroner M.D.
, 19 (Address) Dexter Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Dexter Cemetery
DATE OF BURIAL: 9/17 1928

20. UNDERTAKER: C. O. Bugg
ADDRESS: Dexter Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD