

AUG 1 1939

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

25475  
Do not use this space.

## 1. PLACE OF DEATH

(a) County Dade Registration District No. 240  
(b) Township North Primary Registration District No. 5332 Registered No. \_\_\_\_\_  
(c) City Greenfield, Mo. (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Margaret Jane McGuire

(a) Residence, No. Greenfield, Mo. R.F.D. St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED  
HUSBAND OF Tom McGuire  
(OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 6, 1866.

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
73 4 3

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc. House keeping.  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cedar Co. Mo.13. NAME Dauthard Hastings.14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known15. MAIDEN NAME Sara A. Long16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known17. INFORMANT (ADDRESS) Mrs. Lora Frye.  
Greenfield, Mo.18. BURIAL, CREMATION, OR REMOVAL PLACE Pleasant Grove DATE June, 21, 193919. FUNERAL DIRECTOR (NAME) (ADDRESS) J. W. Ward  
Greenfield, Mo.

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_ Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 19, 1939

22. I HEREBY CERTIFY, That I attended deceased from July 10, 1938, to June 17, 1939  
I last saw him alive on June 17, 1939. Death is said to have occurred on the date stated above, at 12:45 P.M.  
The principal cause of death and related causes of importance were as follows:

Myocarditis, Acute Date of onset 11/4/39  
Arteriosclerosis, General 1930  
Complicated by  
Cerebral Hemorrhage 7/8/38  
Other contributory causes of importance:  
Nephritis chronic 1936

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify \_\_\_\_\_  
(Signed) J. D. Shannon M.D.  
Greenfield, Mo.  
216 (Address) \_\_\_\_\_

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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 .....

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

25-475

Do not use this space.

1. PLACE OF DEATH

(a) County Nada Registration District No. 240  
 (b) Township North Primary Registration District No. 3332 Registered No. ....  
 (c) City ..... (d) Street No. .... St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Margaret Jane McQuire  
 (a) Residence, No. Greenfield mo St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wid  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Tom McQuire  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2-6-1866  
 7. AGE YEARS 73 MONTHS 4 DAYS 3 If LESS than 1 day, hrs. or min.  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House  
 9. Industry or business in which work was done, as saw mill, bank, etc. keeping  
 10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-19-1939

22. I HEREBY CERTIFY, That I attended deceased from .....

to ....., 19..... Death is said

I last saw him alive on ....., 19.....

to have occurred on the date stated above, at .....

The principal cause of death and related causes of importance were as follows:

myocarditis-acute Date of onset 11/11/19  
arteriosclerosis-general 1730  
Complicated by  
Cerebral Hemorrhage 7/8/13

Other contributory causes of importance:

nephritis chronic 1936

12. BIRTHPLACE (CITY OR TOWN) Cedar co  
 (STATE OR COUNTRY) mo

FATHER 13. NAME Southard Hastings

14. BIRTHPLACE (CITY OR TOWN) unknown  
 (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Sarah A. King

16. BIRTHPLACE (CITY OR TOWN) unknown  
 (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) Mrs. King  
Greenfield mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Pleasant Grove DATE 6-21-1939

19. FUNERAL DIRECTOR (ADDRESS) J. D. Shymura  
Greenfield mo

20. FILED Sept 8 1939 W. C. Parson  
 Local Registrar

Name of operation .....

What test confirmed diagnosis? .....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? .....

Where did injury occur? .....

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) J. D. Shymura DO

(Address) Greenfield mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE. AS PRESCRIBED BY LAW.

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