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FILED APR 8 1940

STANDARD CERTIFICATE OF DEATH

State File No. 11384

Registration District No. 417

Primary Registration District No. 556 L.A.D.s.

Registrar's No. 38

1. PLACE OF DEATH:

(a) County Jasper  
(b) City or town Joplin RURAL  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2  
(Specify whether years, months or days) 60

3. (a) PRINT FULL NAME John C. Mc Guire  
(b) If veteran, name war  
(c) Social Security No.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
(b) Name of husband or wife Mary E. Mc Guire 6. (c) Age of husband or wife if alive 78 years  
7. Birth date of deceased Feb 8, 1855 (Month) (Day) (Year)

8. AGE: Years 85 Months 1 Days 3 If less than one day hr. min.

9. Birthplace Laclede County Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business Miner

MOTHER FATHER { 12. Name Calvin Mc Guire  
13. Birthplace Unknown (City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant Mary E. Mc Guire  
(b) Address R # 1 Joplin Mo.

17. (a) Burial (b) Date thereof Mar 13 1940 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centerville Cem.

18. (a) Signature of funeral director Webb City Undertaker

(b) Address Webb City Mo

19. (a) MCH-12-40 (b) J. L. [Signature] (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper  
(c) City or town Joplin (If outside city or town limits, write "RURAL")  
(d) Street No. R # 1 (If rural, give location)  
(e) If foreign born, how long in U. S. A. 7 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 11 year 1940 hour 2:30 minute 6 M.  
21. I hereby certify that I attended the deceased from March 8, 1940, to March 11, 1940, that I last saw him alive on March 10, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death: Acute obstruction of Duodenum

Due to Senility

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations  
Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? While at work? (Specify type of place) (e) Means of injury

23. Signature B. A. [Signature] (M. D. or other)  
Address Webb City Mo Date signed 3/12/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 6,

District File Number 440-938

Date Filed APR 4 1940

1221

**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 A. K. Mills  
Licensed Embalmer No. 347  
P. O. Address Keokuk City, Mo

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. **11384**

Registration District No. **417**

Primary Registration District No. **5561A**

Registrar's No. \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Jackson**  
(b) City or town **Jackson Mo**  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME

**John C McGuire**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex \_\_\_\_\_ 5. Color or race \_\_\_\_\_ 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years  
7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Mar** day **11** year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

**acute obstruction of bowel**  
Due to **I think it was a colic. As they would not permit an autopsy**

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings **Stomach for sure**  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically. **12719**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_ While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature **B. A. Dumbould** (Physician or other) \_\_\_\_\_

Address **W. 1st City, Mo** \_\_\_\_\_ signed

SUPPLEMENTAL

11384 (1940)