

SEP 23 1940

Registration District No. **238**Primary Registration District No. **5615**Registrar's No. **3**

1. PLACE OF DEATH:

(a) County **LACLEDE**
 (b) City or town **AUBURN TWP**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution **R. 2 Sleeper Tr. 2**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community **65-6-22** years, months or days)

3. (a) PRINT FULL NAME

JAMES ANDREW McGUIRE 760

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **M**5. Color or race **W**6. (a) Single, widowed, married, divorced **MARRIED**6. (b) Name of husband or wife **FLORENCE BLACKBURN**6. (c) Age of husband or wife if alive **62** years7. Birth date of deceased **JAN 18 1875**
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

65**6****22**

hr. min.

9. Birthplace **CAMDEN Co MO**
(City, town, or county) (State or foreign country)10. Usual occupation **FARMER**

11. Industry or business

12. Name **NATHANIEL McGUIRE**13. Birthplace **TENN**
(City, town, or county) (State or foreign country)14. Maiden name **MARIE BAKER**
(City, town, or county) (State or foreign country)15. Birthplace **MO**
(City, town, or county) (State or foreign country)16. (a) Informant's own signature **Physician - Thure**(b) Address **Sleeper Tr. R. 1**17. (a) **BURIAL** (b) Date thereof **8 23 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **MT. ARO. CEM.**18. (a) Signature of funeral director **Johnnie**(b) Address **Johnson Tr.**19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **LACLEDE**
 (c) City or town **RURAL**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **SLEEPER R. 1**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **AUG** day **10**
year **1940** hour **7** minute **25 A. M.**

21. I hereby certify that I attended the deceased from

March 1, 1940 to Aug 10, 1940
that I last saw him alive on **Aug 8, 1940**
and that death occurred on the date and hour stated above.

Immediate cause of death

**Cerebral Hemorrhage of Reticular
Arteriole** Duration **39**

Due to _____

Due to **40**Other conditions **none**
(Include pregnancy within 3 months of death)

Major findings:

Of operations **none**Of autopsy **none**

PHYSICIAN

Underline the cause to which death should be charged statistically.

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?
405 (Specify type of place)
 While at work? _____ (e) Means of injury _____
 23. Signature **E. G. Leibson M.D.** (M. D. or other) **1**
 Address **Caed street MO** Date signed **8-15-40**

RECEIVED

District Health Officer No. 7,

District File Number 9-40-1367

Date received 9-18-40

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

W. B. Babner

Licensed Embalmer No. 1161

P. O. Address Lebanon 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

State File No. **28901**

Registration District No. **450**

Primary Registration District No. **SL 10-**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Laclede**
(b) City or town **Anglemont, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(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) **PRINTED FULL NAME**
James Andrew McQuire

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

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **m**

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
65- 6 22 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) **Aug 14-1940** (b) **D. A. Atkins**
(Date received local registrar) (Registrar's signature)

aug 14-1940

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.

DECEASED CERTIFICATION

20. DATE OF DEATH. Month **aug** day **10**
year _____ 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 _____

Due to _____

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 **T. L. Osborne** (M. D. or other) _____

Address **Camdenton Mo** Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

0491-200000