DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 8 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 5992

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 53

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Cape Girardeau (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Southeast Mo Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 months (Specify whether

In this community 4 months years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cape Girardeau

(c) City or town Rural Gravel Hill (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? no. (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME HANNAH CATHERINE McGUIRE

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Frank McGuire 6. (c) Age of husband or wife if alive — years

7. Birth date of deceased June 6, 1866 (Month) (Day) (Year)

8. AGE: Years 76 Months 8 Days 11 If less than one day hr. min.

9. Birthplace Near Daisy (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business

FATHER
12. Name Henry Statler
13. Birthplace Near Daisy (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Venice Crites
15. Birthplace Near Daisy (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant Earl Berry

(b) Address Burfordville R F D 1

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 18, 1943 (Month) (Day) (Year)

(c) Place: burial or cremation Allen Cemetery

18. (a) Signature of funeral director S C Crocraft

(b) Address Jackson Mo.

19. (a) 2-19-43 (Date received local registrar) (b) F H Phelps (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 17 year 1943 hour 8 minute 30 a.M.

21. I hereby certify that I attended the deceased from Oct 17, 1942, to Feb 17, 1943 that I last saw her alive on Feb 17, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Uremic Intoxication

Due to following:- ① Broken Leg, Complicated by osteo-myelitis ② Nephritis ③ Chronic myocarditis ④ Senility

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration ✓

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) Broken femur (rt)

(b) Date of occurrence 0/6

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

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)

While at work? Yes (e) Means of injury Fall

23. Signature Albert M Estes (M. D. or other)

Address Jackson Mo Date signed 2-19-43

1014

(Licensed Embalmer's Statement on Reverse Side)

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No.

District File Number 343-

Date Filed 3-8-43

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 Gene C. Cracrof

Licensed Embalmer No. 4327

P. O. Address Jackson, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
8-21-41
X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 5-992

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH:
(a) County: Cape Girardeau
(b) City or town: Cape Girardeau (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Southeast Mo. Hosp (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 4 mos. (Specify whether years, months or days)
In this community: 4 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Cape Girardeau
(c) City or town: Rural (If outside city or town limits, write "RURAL")
(d) Street No. ..... (If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Hannah C. McGuire
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: W
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: June (Month) 6 (Day) 1867 (Year)
8. AGE: Years 76 Months 8 Days ..... If less than one day: hr. ..... min.
9. Birthplace: (City, town, or county) ..... (State or foreign country) Mo
10. Usual occupation .....
11. Industry or business .....
MOTHER 12. Name .....
FATHER 13. Birthplace: (City, town, or county) ..... (State or foreign country) .....
MOTHER 14. Maiden name .....
FATHER 15. Birthplace: (City, town, or county) ..... (State or foreign country) .....
16. (a) Informant .....
(b) Address .....
17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....
18. (a) Signature of funeral director .....
(b) Address .....
19. (a) 2-19-'43 (Date received local registrar) (b) H. W. Phelps (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 17 year 1943 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
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

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) Broken femur (rt.)
(b) Date of occurrence Oct. 27, 1942
(c) Where did injury occur? Burfordville (City or town) Cape (County) Mo. (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)
While at work? yes (e) Means of injury fall
23. Signature Albert M. Estes (M. D. or other)
Address Jackson Mo. Date signed 2-18-'43

SUPPLEMENTARY
186a
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