

**FILED AUG 11 1943**

Registration District No. **1**

Primary Registration District No. **3000**

Registrar's No. **196**

**1. PLACE OF DEATH:**

(a) County **Adair**  
(b) City or town **Kirksville**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Stickles Hosp. S**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **during life**  
(Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Mo** (b) County **Adair, 10.5**  
(c) City or town **Ironmastle**  
(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 **Joyce Anne Muir**  
3. (b) If veteran, name war **✓** 3. (c) Social Security No. **✓**

**MEDICAL CERTIFICATION**  
20. DATE OF DEATH: Month **July** day **18**  
year **43** hour **6:00** minute **00P.** M.  
21. I hereby certify that I attended the deceased from **July 17**, 19**43** to **July 18**, 19**43**

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Single**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

that I last saw her alive on **July 18, 43**, 19**43** and that death occurred on the date and hour stated above.  
Immediate cause of death **(Myocarditis) Foramen Ovale (Blue Baby)**  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

7. Birth date of deceased **July 17 1943**  
(Month) (Day) (Year)  
8. AGE: Years \_\_\_\_\_ Months **1** Days \_\_\_\_\_ If less than one day **4 hr. 30 min.**

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
1572

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

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

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

MOTHER FATHER { 12. Name **Thomas Muir**  
13. Birthplace **Mo**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Virginia Robinson**  
15. Birthplace **Mo**  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant **Thomas Muir**  
(b) Address **Green Castle, Mo**

17. (a) **Burial** (b) Date thereof **7 20 1943**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ringoo, Pa**  
18. (a) Signature of funeral director **Walter S. Reutson**  
(b) Address **Green City, Mo**

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_  
23. Signature **R. Stickler** (M. D. or other) **MD**  
Address **Kirksville Mo** Date signed **7-20-43**

19. (a) **7/23/43** (b) **Miss J. Wagner**  
(Date received local registrar) (Registrar's signature)

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

1  
3  
3

MOTHER FATHER

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 10

District File Number 8-43-1291

Date Filed AUG 10 1943

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 *Archie W. Wade*

Licensed Embalmer No. 3037

P. O. Address *Green 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, fact should be so stated above.