

5-42
17-39
X32873

Registration District No. 297 Primary Registration District No. 6020 Registrar's No. 13

1. PLACE OF DEATH:
(a) County Ray County, Mo.
(b) City or town Rural Crooked River
(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 35 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Florence D. McGuire
3. (b) If veteran, name war. No. 3. (c) Social Security No.

4. Sex female 5. Color or race White
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Claude O. McGuire
6. (c) Age of husband or wife if alive 69 years
7. Birth date of deceased October 17 1879 (Month) (Day) (Year)

8. AGE: Years 64 Months 0 Days 13 If less than one day hr. min.

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

10. Usual occupation housewife

11. Industry or business

12. Name John J. Coffman
13. Birthplace Rockingham Co. Va. (City, town, or county) (State or foreign country)

14. Maiden name Mary Knupp
15. Birthplace Rockingham Co. Va. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. D.A. Bullock
(b) Address Hardin, Mo. Route

17. (a) (Burial, cremation, or removal) burial (b) Date thereof 10 31 43 (Month) (Day) (Year)

(c) Place: burial or cremation Lavelock Cem. Hardin

18. (a) Signature of funeral director John W. Knipschild
(b) Address Hardin Mo.

19. (a) Nov 1-43 (Date received local registrar) (b) Mrs. Char W. Shippard (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County 83
(c) City or town (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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 29 year 1943 hour 3 minute 00 A.M.

21. I hereby certify that I attended the deceased from Aug 1942 to Oct 29 1943 that I last saw her alive on Oct 10 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Occlusion, Cerebral Thrombosis

Due to: 9/4a

Other conditions: (Include pregnancy within 3 months of death) Postmenopausal Psychosis
Major findings: Major Depressive Type (Mental Deterioration)
Of operations: (Mental Deterioration)
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)
(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) (c) Means of injury
23. Signature Carl H. Reed (M. D. or other) Address Hardin Mo. Date signed 10/29/43

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

Licensed Embalmer No. 8,

District File Number

Date Filed 11-11-43

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 me

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

Signed John W. Knipschild

Licensed Embalmer No. 2789

P. O. Address Hardin M.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 297 Primary Registration District No. 6020 Registrar's No. 13

1. PLACE OF DEATH:
 (a) County Ray Co
 (b) City or town Rural Crooked River Imp
(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) PRINT FULL NAME Florence D. McHarris
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased Oct 17
(Month) (Day) (Year)

8. AGE: Years 64 Months 0 Days _____
(Unless than one day _____ 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 _____
(Burial, cremation, or removal) (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 Missouri (b) County RAY
 (c) City or town HARDIN, MO 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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ at _____
 year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
 that 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) _____

(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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER, FATHER

35576