

FILED MAY 10 1944

State File No. _____
Registrar's No. 229

Registration District No. _____

Primary Registration District No. 5938

1. PLACE OF DEATH: Phelps
(a) County Phelps
(b) City or town Rural Arlington Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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 40 years

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

3. (a) PRINT FULL NAME William Maguhn
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years (Month) (Day) (Year) 1863

8. AGE: Years 81 Months 5 Days 8 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farming

11. Industry or business August

MOTHER FATHER { 12. Name John William Maguhn
13. Birthplace Germany (City, town, or county) (State or foreign country) H
14. Maiden name Helen Rose
15. Birthplace Germany (City, town, or county) (State or foreign country) H

16. (a) Informant _____ (b) Address _____

17. (a) Funeral (Burial, cremation, or removal) (b) Date thereof 4-9-44 (Month) (Day) (Year)
(c) Place: burial or cremation mill creek 4-9-44

18. (a) Signature of funeral director Lee Johnson
(b) Address Newburg Mo.

19. (a) 4-8-1944 (Date received local registrar) (b) W. McCall (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 8th year 1944 hour 4:00 minute _____ M.
21. I hereby certify that I attended the deceased from June 1942 to Apr 8 1944 and that I last saw him alive on _____ 1944 and that death occurred on the date and hour stated above.

Immediate cause of death General paralysis
Diabetic
Due to _____
Due to _____
Other conditions (Includes pregnancy within 3 months of death) W

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 0
23. Signature W. McCall (M. D. or other) _____
Address Newburg Mo Date signed 4-8-44

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

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

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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.

Not Embalmed Lee Johnson
Signed.....

..... Licensed Embalmer No..... *3892*

..... P. O. Address..... *Newburg 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15-464

Registration District No. 275 Primary Registration District No. 5923 Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Phelps
 (b) City or town Rural, Livingston sup
(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 Wm Maguhn
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 s
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 81 Months 1 Days _____ (Unless than one day) _____ min.

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

10. Usual occupation _____
11. Industry or business _____
MOTHER FATHER
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 W P Wehmer
(b) Address Newburg Mo
17. (a) _____ **(b) Date thereof** _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____
19. (a) _____ **(b)** A B Cattle _____ (Registrar's signature)
(Date received local registrar) (Date received local registrar)

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) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 19 year 1944 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, and that I 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)

PHYSICIAN
Major findings:
 Of operations _____
 Of autopsy _____
 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 _____ (M. D. or other) _____
Address _____ **Date signed** _____

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

SUPPLEMENTARY

