

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Registration District No. 199 Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution Conley Maternity Hospital
(d) Length of stay: In hospital or institution 29 days
In this community 29 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Kansas (b) County Wyandotte
(c) City or town Kansas City
(d) Street No. 1915 Woodland Blvd
(e) Citizen of foreign country? 2 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Michael Andrew McGuire

3. (b) If veteran, name war no 3. (c) Social Security No. none

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
7. Birth date of deceased April 2 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 29 If less than one day _____ hr. _____ min.

9. Birthplace Kansas City Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation infant

11. Industry or business _____

MOTHER FATHER

12. Name Tirrel Arthur McGuire

13. Birthplace Kansas City Missouri

14. Maiden name Bessie Bernice Gossett

15. Birthplace Plainview Arkansas

16. (a) Informant Mother / Bessie Mc Guire

(b) Address 1915 Woodland, K.C. Kansas

17. (a) burial (b) Date thereof 5-4-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Hill Bur

18. (a) Signature of funeral director Simmons F. Home

(b) Address 1404 8037 K.C. Mo

19. (a) 5-4-45 (b) Seraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 1 year 1945 hour 17 minute 12 P M.
21. I hereby certify that I attended the deceased from Birth April 2 1945 to May 1 1945 that I last saw him alive on May 1 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Bronch. pneumonia Duration _____

Due to Respirator with

Due to _____

Other conditions 107
(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 a worker (Specify type of place) Means of injury _____
23. Signature Arthur W. Duff (M.D. or other) _____
Address 2105 Independence Ave Date signed 5-2-45

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

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MAY 19 1945

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.....

Licensed Embalmer No.....

P. O. Address.....

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.