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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16321**

FILED APR 29 1947

Registration District No. **275**

Primary Registration District No. **6284**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Wright**

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

(c) Name of hospital or institution **Montgomery Township**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **none**
(Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Wright**

(c) City or town **Lynchburg**
(If outside city or town limits, write "RURAL")

(d) Street No. **Montgomery Exp.**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country **No**

3. (a) PRINT FULL NAME **ESTELLA GRANT McGUIRE**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **No**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **25**
year **1947** hour **1:30** minute **PM**

21. I hereby certify that I attended the deceased from **3-24**, 19**47** to **3-24**, 19**47**
that I last saw him alive on **3-24**, 19**47**
and that death occurred on the date and hour stated above.

4. **White** (a) Sex **Female** (b) Race

5. (a) Single, widowed, married, divorced **Married**

6. (a) Name of husband or wife **R. Frank McGuire**

6. (c) Age of husband or wife if alive **1869** years

7. Birth date of deceased **July 10, 1869**
(Month) (Day) (Year)

Immediate cause of death **Chronic Myocarditis**

Duration **1 week**

8. AGE: Years **77** Months **9** Days **15**
If less than one day hr. min.

Due to **Chronic Myocarditis**

Due to _____

9. Birthplace **Wright Co., Missouri**
(City, town or county) (State or foreign country)

Other conditions **930**
(Include pregnancy within 3 months of death)

10. Usual occupation **Housewife**

Major findings: Of operations _____

11. Industry or business _____

Of autopsy _____

12. Name **Joseph Roberts**

PHYSICIAN _____

13. Birthplace **Tennessee**
(City, town or county) (State or foreign country)

Underline the cause to which death should be charged statistically.

14. Maiden name **Mary Roberts**

15. Birthplace **Tennessee**
(City, town, or county) (State or foreign country)

16. (a) Informant **Opsh Bennett**

(b) Address **Mountain Grove, Mo.**

17. (a) **Burial** (b) Date thereof **3/26/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Dutch Chapel**

18. (a) Signature of funeral director **Russell Barber**

(b) Address **Mtn. Grove, Mo.**

19. (a) **5-18-47** (b) **E. B. Garner**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury **2**

23. Signature **W. E. Gray** (M. D. or other) **DD**

Address **Mountain Grove** Date signed **3-27-47**

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

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

Russell Barber

Licensed Embalmer No. *3848*

P. O. Address

Mtn. Grove, N.C.

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. *May*Registration District No. *375*Primary Registration District No. *6284*Registrar's No. *19*

1. PLACE OF DEATH:

- (a) County *Wright*
 (b) City or town *Lynchburg*
 (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 days3. (a) PRINT
FULL NAME*Estelle J. McJannet*3. (b) If veteran,
name war3. (c) Social Security
No.

4. Sex

*W*5. Color or
race *W*6. (a) Single, widowed, married,
divorced *M*

6. (b) Name of husband or wife

6. (c) Age of husband or wife if
alive

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

if less than one day

*77**9**10**Mo**hr.**min.*

9. Birthplace

(City, town, or county)

(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

(City, town, or county)

(State or foreign country)

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

15. (a) Signature of funeral director

(b) Address

19. (a) *May 10, 1947*
(Date received local registrar)(b) *E. B. Garner*
(Registrar's signature)

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 *May*
 year *1947* hour *21* minute *25* M.
 21. I hereby certify that I attended the deceased from
 to
 that I last saw him alive on
 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 sta-
tistically.

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

16321