

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 9 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43283**
Registrar's No. **11938**

Registration District No. **318** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis Children's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Jerry Quincke McGuire
3. (b) If veteran name war Minor 3. (c) Social Security No. _____

4. Sex male 5. Color or race Negro 6. (a) Single, widowed, married, divorced 5
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 3 - 18 - 47
(Month) (Day) (Year)

8. AGE: Years 1 Months 8 Days 23 If less than one day hr. _____ min. _____

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

10. Usual occupation Minor

11. Industry or business _____

MOTHER FATHER

12. Name Alex McGuire

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

14. Maiden name Ella Bostic

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

16. (a) Informant E. Marsden

(b) Address 5093 Washington

17. (a) Anatomical Board Date thereof DEC 30 1947
(Burial, cremation, or removal) (Month) (Day) (Year)
Anatomical Board

(c) Place: burial or cremation _____

18. (a) Signature of funeral director H. F. Rowland

(b) Address 4355 Washington

19. (a) DEC 30 1947 (b) J. F. Breda
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month December day 11
year 47 hour 7 minute 45 P.M.
21. I hereby certify that I attended the deceased from 12-3-47 to 12-11-47
that I last saw him alive on 12-11-47
and that death occurred on the date and hour stated above.

Immediate cause of death aspiration of vomitus Duration _____

Due to Debilitation due to underlying disease characterized by hepato-splenomegaly & anemia

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: 75
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) Accident

(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 Gilbert B. Foster (M. D. or other) _____

Address 630 S. University Date signed 12-11-47

88611

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 Chas. R. Howell

Licensed Embalmer No. 245

P. O. Address R 834 Hamble

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.