

WRITE PLAINLY—USING BLACK INK—MAKE A PERMANENT RECORD

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MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JUL 14 1948
Registration District No. 318

State File No. 21728
Registrar's No. 1623

Primary Registration District No. 6076
1005

1. PLACE OF DEATH: St. Louis
(a) County: St. Louis
(b) City or town: Manchester, Mo.
(c) Name of hospital or institution: Pine Crest Nursing Home
(d) Length of stay: 3 years
In this community 3 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: St. Louis
(c) City or town: Manchester
(d) Street No. No. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: McQUIRE, ROBERT
3. (b) If veteran, name war:
3. (c) Social Security No.:

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 4
year 1948 hour 11 minute 11 M.
21. I hereby certify that I attended the deceased from Feb 1 1946 to 19...
that I last saw him alive on 19...
and that death occurred on the date and hour stated above.
Immediate cause of death: cerebral hemorrhage
Duration

4. Sex: Male
5. Color or race: W.
6. (a) Single, widow, married, divorced, *not quite*
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: 15 years
7. Birth date of deceased: June 15, 1866
8. AGE: Years 81 Months 11 Days 19

Due to: 83a
Due to:
Other conditions:
Major findings:
Of operations:
Of autopsy:
PHYSICIAN
Underline the cause of which death should be charged statistically.

9. Birthplace: Virginia
10. Usual occupation: Nil
11. Industry or business:
12. Name: Robert McQuire
13. Birthplace: Virginia
14. Maiden name: Agnes Howard
15. Birthplace: Virginia
16. (a) Informant: Pine Crest Nursing Home Records
(b) Address: Manchester, Mo
17. (a) Anatomical board Date thereof: JUN 30 1948
(b) Address: Rowland Mortuary Service 4104 Manchester Ave.
18. (a) Signature of funeral director: J. F. B...
(b) Address: 4104 Manchester Ave.
19. (a) JUN 30 1948 (b) J. F. B...
Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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?:
(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: G. Y. M... M. D. or other
Address: 3507 Tolson Date signed: 6-2-48

6061909
Bob [unclear]

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
Registrar's No. 1623

Registration District No. 317

Primary Registration District No. 6076

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Manchester
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Robert McAnis
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 but
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____
alive _____ years
7. Birth date of deceased: June 15 1948
(Month) (Day) (Year)

8. AGE: Years 81 Months _____ Days _____ If less than one day _____ hr. _____ min. 09
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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(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 _____ (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 _____, Year _____, hour _____, minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

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 _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

MOTHER FATHER

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

5-21728