

FILED APR 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9330**

Harris

72
03

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

BIRTH NO. _____		REG. DIST. NO. 242		PRIMARY REG. DIST. NO. 4362		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY New Madrid				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE Mo. b. COUNTY New Madrid				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Morehouse		c. LENGTH OF STAY (in this place) 1 year		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Morehouse				
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location)				
3. NAME OF DECEASED (Type or Print) William			a. (First)	b. (Middle)	c. (Last) McGuire	4. DATE OF DEATH (Month) (Day) (Year) March 31 1949		
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH April 02 1881		9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months 11	IF UNDER 24 hrs. Days Hours Min. 29
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Ret. Farmer		11. BIRTHPLACE (State or foreign country) Mayfield Ky.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME William McGuire			13b. MOTHER'S MAIDEN NAME Dk		14. NAME OF HUSBAND OR WIFE Katy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Noble McGuire Dexter Mo.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Embolism ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause: (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4201				INTERVAL BETWEEN ONSET AND DEATH 1 week		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Morehouse New Madrid Mo				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from 3-24 , 19 49 , to 3-31 , 19 49 , that I last saw the deceased alive on 3-31 , 19 49 and that death occurred at 2:30 A.M. , from the causes and on the date stated above.								
23a. SIGNATURE A.M. Harris M.D. (Degree or title)				23b. ADDRESS Morehouse Mo.		23c. DATE SIGNED 3-31-49		
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 4-2-49	24c. NAME OF CEMETERY OR CREMATORY Dexter City		24d. LOCATION (City, town, or county) (State) Dexter Mo.			
DATE REC'D BY LOCAL REG. 4-8-49		REGISTRAR'S SIGNATURE Thomas M. Shetter			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Welch Funeral Home - Sikeston Mo			

RECEIVED

District Health Office No. 2,

District File Number 449-475

Date Filed 4-12-49

AUG 4 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Raymond Crows

Signed _____
Student Embalmer

Licensed Embalmer No. 3467

P. O. Address Litchton 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.