

FILED MAY 10 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13270**
 BIRTH NO. 2 REG. DIST. NO. 254 PRIMARY REG. DIST. NO. 4386 Registrar's No. 12

1. PLACE OF DEATH a. COUNTY Oregon		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Oregon	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Thayer		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Thayer	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) a. (First) Martha b. (Middle) Jane c. (Last) McGuire			4. DATE OF DEATH (Month) (Day) (Year) Jan 7 1949
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 29, 1895
9. AGE (In years last birthday) 53		10. MONTHS 8	11. DAYS 8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Sitka, Arkansas
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME William Hurst	
13b. MOTHER'S MAIDEN NAME Rebecca Swafford		14. NAME OF HUSBAND OR WIFE Robert McGuire	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Robert W. McGuire		ADDRESS	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Right Femur. INTERVAL BETWEEN ONSET AND DEATH 2 year	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		1991	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Carcinoma	
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.	
23a. SIGNATURE R W Cooper M.D.		23b. ADDRESS Thayer MO	
23c. DATE SIGNED		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 1/9/49		24c. NAME OF CEMETERY OR CREMATORY Thayer Cemetery	
24d. LOCATION (City, town, or county) (State) Thayer Missouri		25. FUNERAL DIRECTOR'S SIGNATURE Ella Crass	
DATE REC'D BY LOCAL REG. 4-17-1949		25. ADDRESS Thayer, MO.	

(Licensed Embalmer's Statement on Reverse Side)

COOPER

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

No. 300
10-48

RECEIVED

District Health Officer No. 5

District File Number 549337

Date Filed 5-6-49

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.

Student
Student Embalmer

Signed Richard Carter

Licensed Embalmer No. 4576

P. O. Address Thayer, 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.