No. 300
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FILED MAR 31 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10787

State File No. .....

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2830

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

1. PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ST. LOUIS MO

c. LENGTH OF STAY (in this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4752 MINNESOTA

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE MISSOURI b. COUNTY 2159

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ST. LOUIS

d. STREET ADDRESS (If rural, give location) 15 4721 PENNSYLVANIA

3. NAME OF DECEASED (Type or Print) a. (First) JAMES b. (Middle) J. c. (Last) MAGUIRE

4. DATE OF DEATH (Month) (Day) (Year) MAR. 23 1950

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED

8. DATE OF BIRTH MAY 29 1871

9. AGE (In years last birthday) 78 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nil

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) MISSOURI

12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME HUGH MAGUIRE

13b. MOTHER'S MAIDEN NAME CATHERINE DANIAL

14. NAME OF ~~HUSBAND~~ OR WIFE ANNA B. MAGUIRE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S SIGNATURE OR NAME ADDRESS CATHERINE CALLEWEART 4752 MINNESOTA

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Prostate — INTERVAL BETWEEN ONSET AND DEATH 2 yr

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Metastasis to liver and lung — 9 mo

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

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) 1777

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1947, *to* March, 1950, *that I last saw the deceased alive on* 23 March, 1950, *and that death occurred at* 11:45 a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Willem D. Susanka M.D.

23b. ADDRESS 4205 Virginia

23c. DATE SIGNED 23 March 50

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24b. DATE MAR. 27, 1950

24c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEM.

24d. LOCATION (City, town, or county) (State) ST. LOUIS MO

DATE REC'D BY LOCAL REG. MAR 25 1950

REGISTRAR'S SIGNATURE J. B. Foster

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Kutis 2906 Gravois

(Licensed Embalmer's Statement on Reverse Side)

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 Leo J. Budde

Licensed Embalmer No. 3989

P. O. Address St. Louis, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.