No. 300
10.48

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

FILED JUL 29 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23604 23604
3007

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN: Kansas City
c. LENGTH OF STAY (in this place): 3 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION: Little Sisters of the Poor

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Kansas
b. COUNTY: Atchison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Effingham
d. STREET ADDRESS (If rural, give location): 5150 X

3. NAME OF DECEASED (Type or Print)
a. (First): John
b. (Middle):
c. (Last): Maguire

4. DATE OF DEATH (Month) July (Day) 9 (Year) 1950

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Nov. 15 1866
9. AGE (In years last birthday): ~~84~~ 83 | 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): Own Business
10b. KIND OF BUSINESS OR INDUSTRY: Contractor
11. BIRTHPLACE (State or foreign country): Whitewater Wisconsin
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13a. FATHER'S NAME: John Maguire
13b. MOTHER'S MAIDEN NAME: Mary Ann Cully
14. NAME OF HUSBAND OR WIFE: Sybilla Maguire
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S SIGNATURE OR NAME: Sister Emilie, ADDRESS: 5331 Highland

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) Acute Cardiac Dilatation — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Sclerosis — years
DUE TO (c) Generalized Arteriosclerosis — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

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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)
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 January, 1942, to July, 1950, that I last saw the deceased alive on 2 July, 1950, and that death occurred at 10 a.m., from the causes and on the date stated above.

23a. SIGNATURE R. Glenn Elliott (Degree or title) MD
23b. ADDRESS: Kansas City, Missouri
23c. DATE SIGNED: July 10, 50

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: July 10, 1950
24c. NAME OF CEMETERY OR CREMATORY: Effingham Cemetery
24d. LOCATION (City, town, or county) (State): Effingham Kansas

DATE REC'D BY LOCAL REG.: 7-10-50
REGISTRAR'S SIGNATURE: Geraldine Holmes
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Jos. A. Butler's Sons, Kansas City 2, Kansas

(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: Ron Reel

Licensed Embalmer No. 3426 Mo

P. O. Address Kansas City Kansas

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.