

FILED NOV 3 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35072

State File No. _____

318

1003

9127

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Alexian Bros. Hosp.		4. STREET ADDRESS (If rural, give location) 1105 Russell	

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) c. (Last) McGuire			4. DATE OF DEATH (Month) (Day) (Year) 10/24/50		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH May 3, 1891	9. AGE (In years last birthday) 59	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dispatcher for AAA		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Edna	
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 Joseph Ablan--808 Geyer	
18. CAUSE OF DEATH Enter 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) Internal Haemorrhage			INTERVAL BETWEEN ONSET AND DEATH 3 hrs

18. ANTECEDENT CAUSES DUE TO (b) Carcinoma Right Lung		1 month			
DUE TO (c) Metastasis left lung		1 month			
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 <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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 163X	

22. I hereby certify that I attended the deceased from 9-21, 1950, to 10-24, 1950, that I last saw the deceased alive on 10-24, 1950, and that death occurred at 7:00a m., from the causes and on the date stated above.

23a. SIGNATURE J. B. Laster M.D.		23b. ADDRESS 3739 Gravois		23c. DATE SIGNED 10/24/50	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10/26/50		24c. NAME OF CEMETERY OR CREMATORY SS Peter & Paul Cem.		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
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DATE REC'D BY LOCAL REG. 907 24 1950		REGISTRAR'S SIGNATURE J. B. Laster		25. FUNERAL DIRECTOR'S SIGNATURE Wacker-Heldler		ADDRESS 3634 Gravois Ave	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUL 21 1952

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed.....
Frank J. Offand Jr.

Licensed Embalmer No.....
2645

P. O. Address.....
St Paul, Minn

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.