

FILED JAN 31, 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2762

1003

673

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

1. PLACE OF DEATH
a. COUNTY _____
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis
c. LENGTH OF STAY (In this place) _____
d. FULL NAME OF HOSPITAL OR INSTITUTION 143 N. Euclid

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo.
b. COUNTY _____
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2129
d. STREET ADDRESS (If rural, give location) 143 N. Euclid

3. NAME OF DECEASED (Type or Print)
a. (First) EMERSON b. (Middle) H. c. (Last) McGuire
4. DATE OF DEATH (Month) (Day) (Year) 1 6 51

5. SEX Male 6. COLOR OR RACE White 7. MARRIED-NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 8. DATE OF BIRTH 9 AM 1892 9. AGE (In years last birthday) (Months) (Days) (Hours) (Mins.) 57

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WRK 10b. KIND OF BUSINESS OR INDUSTRY WRK 11. BIRTHPLACE (State or foreign country) Ill 12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME WRK 13b. MOTHER'S MAIDEN NAME WRK 14. NAME OF HUSBAND OR WIFE WRK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) WRK 16. SOCIAL SECURITY NO. WRK 17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS T. V. Vayn / 1300 Clark

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.
ANTECEDENT CAUSES (b) _____
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.) Cardiac Hypertrophy

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) (Min.) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? H21.1

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 _____ from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) [Signature] 23b. ADDRESS 1300 Clark 23c. DATE SIGNED 1/6/51

24a. BURIAL, CREMATION, REMOVAL (Specify) _____ 24b. DATE JAN 23 1951 24c. NAME OF CEMETERY OR CREMATORY Anatomical Board 24d. LOCATION (City, town, or county) (State) _____

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JAN 23 1951 J. B. Sarata 25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Rowland Mortuary Service Inc.

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

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

Students of Mortuary College

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed.....

James D. Lammers

Licensed Embalmer No. *4192*

P. O. Address *St Louis*

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.