

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24296**

BIRTH NO. _____ REG. DIST. NO. **139** PRIMARY REG. DIST. NO. **5534** Registrar's No. **57**

3440
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY HOLT		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY HOLT	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN FOREST CITY FOREST		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN FOREST CITY FOREST TWP.	
c. LENGTH OF STAY (in this place) 50 YRS.		d. STREET ADDRESS (If rural, give location) NONE	
d. FULL NAME OF HOSPITAL OR INSTITUTION NONE			

3. NAME OF DECEASED (Type or Print) a. (First) ADELIA	b. (Middle)	c. (Last) MAGUIRE	4. DATE OF DEATH (Month) (Day) (Year) JULY 28 1952
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, NEVER MARRIED	8. DATE OF BIRTH MAY 16, 1870	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months	IF UNDER 1 WEEK Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) COUNCIL BLUFFS, IOWA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME UNKNOWN	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE NONE
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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. NONE	17. INFORMANT'S SIGNATURE OR NAME WELFARE OFFICE	ADDRESS MOUND CITY MO.
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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		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CEREBRAL HEMORRHAGE		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) CEREBRAL HEMORRHAGE IN NOV. 1950 DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. CANCER OF SIGMOID		6 MONTHS	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 352X H	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Nov. 1950**, to **July 28, 1952**, that I last saw the deceased alive on **July 28, 1952**, and that death occurred at **2 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE Howard E. Collins D.O.	23b. ADDRESS Oregon Mo.	23c. DATE SIGNED 7-28-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE JULY 31, 1952	24c. NAME OF CEMETERY OR CREMATORY FOREST CITY	24d. LOCATION (City, town, or county) (State) FOREST CITY, MO.
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DATE REC'D BY LOCAL REG. 8-1-52	REGISTRAR'S SIGNATURE James H. Crawford	25. FUNERAL DIRECTOR'S SIGNATURE James H. Pettigrew	ADDRESS Oregon Mo
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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

James H. Pettigrew

Licensed Embalmer No. *3192*

P. O. Address

Oregon 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.