

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39415**
Registrar's No. **220**

FILED DEC 10 1953

BIRTH NO. _____ REG. DIST. NO. **150** PRIMARY REG. DIST. NO. **5572**

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

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Prairie Township		c. LENGTH OF STAY (in this place) 7 da.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jackson County Hospital		d. STREET ADDRESS (If rural, give location) R #4 City - East Main	
3. NAME OF DECEASED (Type or Print) a. (First) MELINDA b. (Middle) M. c. (Last) McGuire		4. DATE OF DEATH (Month) 12 (Day) 1 (Year) 1953	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 1-29-1907
9. AGE (In years last birthday) 46		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Helena, Montana
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Chester Lewis		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE James McGuire		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 487-26-724x		17. INFORMANT'S SIGNATURE OR NAME James McGuire ADDRESS Blue Springs Mo	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac failure INTERVAL BETWEEN ONSET AND DEATH ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. ascites	
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?		22. I hereby certify that I attended the deceased from 11-24- , 1953, to 12-1- , 1953, that I last saw the deceased alive on 12-1- , 1953, and that death occurred at 3:23pm , from the causes and on the date stated above.	
23a. SIGNATURE M. E. Keith M.D. (Degree or title)		23b. ADDRESS R#4 Independence, Mo.	
23c. DATE SIGNED 12-1-53		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE Dec-4-53		24c. NAME OF CEMETERY OR CREMATORY Blue Springs	
24d. LOCATION (City, town, or county) (State) Blue Springs Mo		25. FUNERAL DIRECTOR'S SIGNATURE W. B. Lunsford ADDRESS Blue Springs Mo	
DATE REC'D BY LOCAL REG. 12-4-53		REGISTRAR'S SIGNATURE M. B. Lunsford	

DEC 13 1967

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 R B Webb

Licensed Embalmer No. 2303

P. O. Address Blue Springs

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.