

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **41974**  
Registrar's No. **435**

FILED JAN 7 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000

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

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Adair</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirkville</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>La Crosse</u>	
c. LENGTH OF STAY (in this place) <u>24 Days</u>		d. STREET ADDRESS (If rural, give location) <u>Rural</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Grim-Smith Memorial Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Winfred</u> b. (Middle) <u>----</u> c. (Last) <u>Magers</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>12 30 53</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>1-30-98 1892</u>		9. AGE (In years last birthday) <u>61</u>		10. F UNDER 1 YEAR Days <u>11</u>	
11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>John Magers</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret Hall</u>		15. NAME OF HUSBAND OR WIFE <u>Jennie Magers</u>		16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>	
17. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		18. BIRTHPLACE (State or foreign country) <u>Missouri</u>		19. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Jennie Magers</u> ADDRESS <u>La Crosse Mo</u>	
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Artery Thrombosis</u> ANTECEDENT CAUSES <u>Coronary artery arteriosclerosis</u> DUE TO (b) _____ DUE TO (c) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u> <u>3-5 yrs</u>	
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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) <u>4201</u>	
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 12-7, 1953, to 12-30, 1953, that I last saw the deceased alive on 12-30, 1953, and that death occurred at 11:2 p. m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>Kirkville, Mo.</u>		23c. DATE SIGNED <u>12-31-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Jan 2 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Indian Hill</u>	
24d. LOCATION (City, town, or county) (State) <u>Adair Mo</u>		24e. NAME OF CEMETERY OR CREMATORY <u>Indian Hill</u>		24f. LOCATION (City, town, or county) (State) <u>Adair Mo</u>	

DATE REC'D BY LOCAL REG. <u>1-4-53</u>		REGISTRAR'S SIGNATURE <u>Kate Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>South Gifford Mo</u>	
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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

*W. N. McCallum*

Licensed Embalmer No. 2052

P. O. Address South Gifford 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.