

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5420

State File No.

FILED MAR 8 1955

BIRTH NO. _____ REG. DIST. NO. 170 PRIMARY REG. DIST. NO. 3033 Registrar's No. 27

1. PLACE OF DEATH a. COUNTY <u>MacLade</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Wright</u>	
b. CITY OR TOWN <u>LEBANON, Mo.</u>	c. LENGTH OF STAY (in this place) <u>5 days</u>	c. CITY OR TOWN <u>Lynchburg</u>	d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Wallace Memorial Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>1190 Montgomery Township 1</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>HORACE</u> b. (Middle) <u>BURTON</u> c. (Last) <u>McGUIRE</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 23, 1955</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>9-23-1882</u>		9. AGE (In years last birthday) <u>72</u> If under 1 year: Months _____ Days _____ If under 4 hrs: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>KNOXVILLE, TENN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Columbus McGUIRE</u>		13b. MOTHER'S MAIDEN NAME <u>Lucy Tate</u>		14. NAME OF HUSBAND OR WIFE <u>Dorothy McGUIRE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>XXX</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Dorothy McGUIRE, Lynchburg, Mo.</u>	

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerosis - Myocardial</u>		
	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. <u>Hemorrhoids (bleeding)</u>		461X <u>6 hrs</u>	

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) (Min.)		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 December 18, 1954, to February 23, 1955, that I last saw the deceased alive on February 23, 1955, and that death occurred at 6:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Paul A. Venturo</u> <u>427</u> (Degree or title)		23b. ADDRESS <u>Knight Bldg. Lebanon, Mo.</u>		23c. DATE SIGNED <u>2-26-55</u>	
24a. BURIAL, CREMATION, OR OTHER DISPOSITION <u>BURIAL</u>		24b. DATE <u>2-27-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Dutch Chapel Cem.</u>	
24d. LOCATION (City, town, or county) (State) <u>Emery, Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Rev. Barb, Wm. H. Mo.</u>			
DATE REC'D BY LOCAL REG. <u>2-27-1955</u>		REGISTRAR'S SIGNATURE <u>Stella S. Gray</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Rev. Barb, Wm. H. Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

MAR 11 1955

Received 3-7-55

Laclede County Health Unit

File No. 28

Date Filed 3-7-55

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.....
Signature of Student Embalmer

Signed RW Barb

Licensed Embalmer No. 38

P. O. Address Puty

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.