

Health,  
Welfare  
Public  
Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
D. M. Eubank

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

8785

FILED APR 10 1957

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1339

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3891 E. 61st St.</b>			Length of stay in <b>60</b> Years		d. STREET ADDRESS <b>3891 E. 61st Street</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Fred</b> Middle <b>B.</b> Last <b>McGuire</b>				4. DATE OF DEATH Month <b>March</b> Day <b>19</b> Year <b>1957</b>			
5. SEX <b>D</b> Male	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 25, 1874</b>		9. AGE (In years last birthday) <b>82</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Sec. to Director</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Kan. City Water Dep.</b>		11. BIRTHPLACE (City and state or country) <b>Fontelle, Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>William D. McGuire</b>				14. MOTHER'S MAIDEN NAME <b>Mary Hill</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Howard E. McGuire 87th and Raytown Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia -</b>							Interval BETWEEN ONSET AND DEATH <b>2 days.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <b>Cerebral hemorrhage + paralysis</b>		2 yrs.		
			DUE TO (c) <b>Arterio sclerosis</b>		10 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE			
21. I attended the deceased from <b>June 1952</b> to <b>March 19, 1957</b> and last saw her/him alive on <b>Mar 18, 1957</b> Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Type or title) <b>D. M. Eubank M.D.</b>				22b. ADDRESS <b>Raytown, Mo</b>		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>March 23, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St Mary's Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Melody McGilley Eylar Kan City, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>3-22-57</b>		26. REGISTRAR'S SIGNATURE <b>neva minshall</b>		

(Licensed Embalmer's Statement on Reverse Side)

2  
Dr David F. Emb  
6252 Poytress Pa  
HL 3-0.100

till 5 wed

---

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em  
by me, or by ....., Student Embalmer No. ....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Melvin Burton*

Licensed Embalmer No. *496*

P. O. Address *KC 7m*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.

