

FILED MAY 10 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12706
Registrar's No. 614

BIRTH NO. _____ REG. DIST. NO. 113 PRIMARY REG. DIST. NO. 5430

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|--------------------------------------------------------------------|-------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Franklin | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Franklin | |
| b. CITY OR TOWN Stanton | c. LENGTH OF STAY (in this place) 2 yrs. | c. CITY OR TOWN Missouri | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Miller Nursing Home | | e. STREET ADDRESS (If rural, give location) _____ | |

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| 3. NAME OF DECEASED (Type or Print) a. (First) Patrick b. (Middle) Francis c. (Last) Maquire | | | 4. DATE OF DEATH (Month) (Day) (Year) May 7 1957 | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed | 8. DATE OF BIRTH Nov 6, 1872 | 9. AGE (In years last birthday) 84 | 10. IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (City and State or Foreign Country) Ohio | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | |

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| 13a. FATHER'S NAME Bernard Maquire | 13b. MOTHER'S MAIDEN NAME McDermot | 14. NAME OF HUSBAND OR WIFE _____ |
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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 Harry Maquire (son) ADDRESS St. Louis |
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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, aneurysm, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Intracranial Cerebral Hemorrhage | | MEDICAL CERTIFICATION INTERVAL BETWEEN SURVIVAL AND DEATH 2 days |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) General Arteriosclerosis | | |
| | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |

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| 19a. DATE OF OPERATION _____ | 19b. MAJOR FINDINGS OF OPERATION _____ | 20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) 331x |
| 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 **5-5-57** to **5-7-57**, 19**57**, that I last saw the deceased alive on **5-6-57**, 19**57**, and that death occurred at **6-4** m., from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) D. W. E. Mitchell M.D. | 23b. ADDRESS St. Clair Mo | 23c. DATE SIGNED 5-8-57 |
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|---------------------------------------------------------|-------------------------------|----------------------------------------------------|-------------------------------------------------------------------|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE May 10, 1957 | 24c. NAME OF CEMETERY OR CREMATORY St James | 24d. LOCATION (City, town, or county) (State) Catawissa Mo |
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| DATE REC'D BY LOCAL REG. 5/8-57 | REGISTRAR'S SIGNATURE Clara Williams | 25. FUNERAL DIRECTOR'S SIGNATURE Mrs. John L. Shuber ADDRESS Pacific, Mo. |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....
Signature of Student Embalmer

Signed *Ralph Oltinen*

Licensed Embalmer No. *4808*

P. O. Address *Union 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.