

FILED OCT 28 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38953
STATE FILE NUMBER

Registration District No. 357 Primary Registration District No. 6218 Registrar's No. 16

5. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Vernon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Dover</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Sheldon RR #3</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Sheldon RR 3</u>		Length of stay in lb <u>1 Mo.</u>	d. STREET ADDRESS (If outside, give location) <u>RR #3</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>ALLEN</u> Last <u>Mc Guire</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>16</u> Year <u>1957</u>	
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>15 May 1892</u>	9. AGE (In years last birthday) <u>65</u>	F UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trash hauling</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Trash</u>	11. BIRTHPLACE (City and state or country) <u>Unknown, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>Harvey McGuire</u>	13b. MOTHER'S MAIDEN NAME <u>MaEtha Wilson</u>	14. NAME OF HUSBAND OR WIFE <u>Ellen Sallisberry</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT <u>Shoreen Funeral Home</u> Address <u>Nevada, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound comminuted fracture of skull</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Probably immediate</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) _____ DUE TO (c) _____		
PART-II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>983X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Struck on head by blunt object</u>
20c. TIME OF INJURY <u>at p.m. 3:00 10/16/57</u>	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. CITY, TOWN, OR LOCATION <u>Vernon</u>	COUNTY <u>Mo</u>	STATE <u>Mo</u>
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21. I attended the deceased from _____ to _____ and last saw her/him alive on Dead when seen
Death occurred at 3:00 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Ray W. Burrell MD</u>	22b. ADDRESS <u>Nevada Mo.</u>	22c. DATE SIGNED <u>10/17/57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>19 OCT</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Flores Wills</u>	23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY, Mo.</u>
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24. FUNERAL DIRECTOR <u>Shoreen Funeral Home</u>	ADDRESS <u>Nevada, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Oct 16 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Ruth Faith</u>
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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

NOV 7 1957

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 *Clay C. McLeod*

Licensed Embalmer No. *4853*

P. O. Address *Florida, Ma,*

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.