

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-012925

FILED VS MAR 3 1 1960

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 3237**

INDEXED

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b	c. CITY OR TOWN <b>St. Louis</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>St. Louis- Little Rock Hospitals, Inc.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1736 Pennsylvania</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Michael Cornelius Maguire</b>			4. DATE OF DEATH Month Day Year <b>March 20 1960</b>		
5. SEX <b>Male</b>	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>2-27-1887</b>	9. AGE (last birthday) <b>73</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>Pensioned Rate Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Michael Maguire</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Cain</b>		14. NAME OF HUSBAND OR WIFE <b>Kate Finnegan Maguire</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>702-14-6040</b>		17. INFORMANT Address <b>Gerald Maguire 3452 a St. Vincent</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>ACUTE HEPATITIS + CHOLANGITIS</b>					INTERVAL BETWEEN ONSET AND DEATH <b>12 DAYS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>CHOLEDOCHOLITHIASIS</b>					UNKNOWN
DUE TO (c) <b>584x</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>THROMBOCYTOPENIA - CAUSE UNKNOWN -</b>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 a.m. p.m. Month, Day, Year					
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>Mar. 8, 1960</b> to <b>Mar. 20, 1960</b> and last saw <sup>xx</sup> him alive on <b>Mar 19, 1960</b> Death occurred at <b>2.10 A.m</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Newbrough M.D.</b>			22b. ADDRESS <b>370 WASHINGTON</b>		22c. DATE SIGNED <b>21 MAR 60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3/23/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
24. FUNERAL DIRECTOR <b>E.J. Schnur</b>		ADDRESS <b>3125 Lafayette</b>		25. DATE RECD. BY LOCAL REG. <b>MAR 21 1960</b>	26. REGISTRAR'S SIGNATURE <b>Coal Smith M.D.</b>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

4. P.

**STATEMENT BY LICENSED EMBALMER**

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Thomas F. Fenwick

Licensed Embalmer No. 379  
P. O. Address 3125 7<sup>th</sup>

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