

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-019035

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2534 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1  
25117

3

4 1

5 2

6

7 0

8 0

9331X

10

11

1296-c

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED MAY 31 1962		1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Jackson</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Kelly Nursing Home</b>		Length of stay in 1b <b>3 Mo</b>		c. CITY OR TOWN <b>St Joseph</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <b>Artes Hotel</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. (If outside, give location) RESIDE ON FARM Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LUCY</b> Middle <b>PRATT</b> Last <b>MAGUIRE</b>			4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>1962</b>		
5. SEX <b>Female</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>5/22/1870</b>	9. AGE (last birthday) <b>91</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>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Hannibal Mo</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>No Record</b>		13b. MOTHER'S MAIDEN NAME <b>No Record</b>	
14. NAME OF HUSBAND OR WIFE <b>Henry E 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>None</b>	
17. INFORMANT <b>202 Anthony Lucille Dailey Santa Cruz Calif.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b>		DUE TO (b) <b>arteriosclerosis</b>		<b>4-5 hrs</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)		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 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 a.m. p.m. Month, Day, Year		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.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>Feb. 1962</b> to <b>4-4-62</b> and last saw her <b>alive on 4/4/62</b> Death occurred at <b>6:30 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>[Signature]</b> (Degree or title)			22b. ADDRESS <b>909 Prof. Bldg. KCMU</b>		22c. DATE SIGNED <b>5/7/62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>5/9/1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>		23d. LOCATION (City, town, or county) <b>St Joseph Missouri</b>
24. FUNERAL DIRECTOR <b>Sheil Funeral Home Kansas City Mo</b> ADDRESS			25. DATE RECD. BY LOCAL REG. <b>5-9-62</b>		26. REGISTRAR'S SIGNATURE <b>[Signature]</b>

USE BLACK INK OR TYPEWRITER RIBBON

**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 Thomas A. Hill

Licensed Embalmer No. 4954

P. O. Address S. P. Hill

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.