

FILED FEB 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1480

State File No.

BIRTH NO. _____ REG. DIST. NO. 150 PRIMARY REG. DIST. NO. 4240 Registrar's No. 20

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|--------------------------------------------------------------------------------------------------------------|-------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>Blue Springs</u> | c. LENGTH OF STAY (in this place) <u>35 yrs</u> | c. CITY (If outside corporate limits, write RURAL and give township) <u>Blue Springs Mo</u> | |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION | | d. STREET ADDRESS (If rural, give location) <u>04 80</u> | |

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| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Charles</u> b. (Middle) <u>Woodie</u> c. (Last) <u>McGuire</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 27-1950</u> | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Dec-6-1886</u> | 9. AGE (In years last birthday) <u>63</u> | IF UNDER 1 YEAR Months <u>1</u> Days <u>21</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Michigan State Camp</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <u>Blue Springs Mo</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> |
| 13a. FATHER'S NAME <u>Wm McGuire</u> | | 13b. MOTHER'S MAIDEN NAME <u>Josephine Parker</u> | 14. NAME OF HUSBAND OR WIFE <u>Leroy McGuire</u> | | |

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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | 16. SOCIAL SECURITY NO. <u>491-22-1688</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Mr Leroy McGuire</u> ADDRESS <u>Blue Springs Mo</u> | |
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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, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u> |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Tuberculosis of the Brain</u> | | |
| | ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a), stating the underlying cause last. DUE TO (b) <u>Military Pulmonary Tbc</u> | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | <u>DO 2X</u> |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) |
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| 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 Dec 1, 1949, to Jan 27, 1950, that I last saw the deceased alive on Jan 26, 1950, and that death occurred at 6 A m., from the causes and on the date stated above.

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|-------------------------------------------------------------|--------------------------------------|---------------------------------|
| 23a. SIGNATURE <u>Merrill R. Bay M.D.</u> (Degree or title) | 23b. ADDRESS <u>Blue Springs Mo.</u> | 23c. DATE SIGNED <u>1-27-50</u> |
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|-------------------------------------------|----------------------------|------------------------------------------------------------|----------------------------------------------------------------------|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE <u>Jan 28-50</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Blue Springs Mo.</u> | 24d. LOCATION (City, town, or county) (State) <u>Blue Springs Mo</u> |
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| DATE REC'D BY LOCAL REG. <u>JAN. 28, 1950</u> | REGISTRAR'S SIGNATURE <u>Donald C. Earnshaw</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs G B Webb - Son</u> ADDRESS <u>Blue Springs Mo</u> |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

480

FEB 6 1950

APR 6 1950

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 _____
Student Embalmer

Signed R B Webb

Licensed Embalmer No. 2353

P. O. Address Blue Springs 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 this body is not embalmed, fact should be so stated above.