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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21079

State File No. .....

BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 126

1. PLACE OF DEATH
a. COUNTY ST. CHARLES
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ST. CHARLES
c. LENGTH OF STAY (in this place) 7 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. JOSEPH HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE ILLINOIS
b. COUNTY GREENE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) CARROLLTON 8120
d. STREET ADDRESS (If rural, give location) None

3. NAME OF DECEASED (Type or Print)
a. (First) FRANK
b. (Middle) NONE
c. (Last) McGUIRE

4. DATE OF DEATH (Month) JUNE (Day) 28 (Year) 1951

5. SEX M D
6. COLOR OR RACE W
7. ~~MARRIED~~, NEVER MARRIED, ~~WIDOWED~~, ~~DIVORCED~~ (Specify) D
8. DATE OF BIRTH Oct 26 1877
9. AGE (In years last birthday) 73 — IF UNDER 1 YEAR: Months 8, Days 2 — IF UNDER 24 HRS.: Hours —, Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR
10b. KIND OF BUSINESS OR INDUSTRY FARM LABOR
11. BIRTHPLACE (State or foreign country) ILLINOIS
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Unknown
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME ST. JOSEPH HOSPITAL ADDRESS St CHARLES MO.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Embolis — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Gastric ulcers multiple — 6 mo.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. 5400

19a. DATE OF OPERATION 6-25-51
19b. MAJOR FINDINGS OF OPERATION Multiple Gastric ulcerations
20. AUTOPSY? YES ☒ NO ☐

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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-22, 1951, *to* 6-28, 1951, *that I last saw the deceased alive on* 6-28, 1951, *and that death occurred at* 4:30P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Russell J Lieder M.D.
23b. ADDRESS O St Charles Mo.
23c. DATE SIGNED 6-29-51

24a. BURIAL, CREMATION, REMOVAL (Specify) 5
24b. DATE 6-28-51
24c. NAME OF CEMETERY OR CREMATORY Wilson
24d. LOCATION (City, town, or county) (State) Batchtown Ill.

DATE REC'D BY LOCAL REG. 6-29-51
REGISTRAR'S SIGNATURE Nannie Hamilton 284
25. FUNERAL DIRECTOR'S SIGNATURE Loyal H. Linthicum
ADDRESS Hardin Ill.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
JUL -2 1951
DISTRICT HEALTH OFFICE No. 4
File No. .....

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.