

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **7799**FILED MAR 22 1954
BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **283**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Kansas b. COUNTY Doniphan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	c. LENGTH OF STAY (If in place) 1 week	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Troy	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Missouri Methodist Hosp.		d. STREET ADDRESS (If rural, give location) 8150 S	

3. NAME OF DECEASED (Type or Print) a. (First) Minnie b. (Middle) _____ c. (Last) McGregor		4. DATE OF DEATH (Month) (Day) (Year) March 21 1954	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 22 1879
9. AGE (In years, by birthday) 75 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Mins. _____		11. BIRTHPLACE (State or foreign country) Kansas	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
12. CITIZEN OF WHAT COUNTRY? USA			

13a. FATHER'S NAME Perry Abbett	13b. MOTHER'S MAIDEN NAME Sarah Hamilton	14. NAME OF HUSBAND OR WIFE Robert McGregor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Robert McGregor
		ADDRESS Troy Kansas	

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral embolism		INTERVAL BETWEEN ONSET AND DEATH 7 weeks
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Symphycarcoma of Thyroid		6 wks
	DUE TO (c) Chronic myocarditis 194X		6 yrs
19a. DATE OF OPERATION 3-6-54	19b. MAJOR FINDINGS OF OPERATION Paratracheal pressure due to thyroid tumor		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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)	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 **March 3, 1954**, to **March 11, 1954**, that I last saw the deceased alive on **Mar 10, 1954**, and that death occurred at **1 A** m., from the causes and on the date stated above.

23a. SIGNATURE Paul Furgraves		(Degree or title) MD	23b. ADDRESS St Joseph Mo	23c. DATE SIGNED 3-11-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 3/11/54	24c. NAME OF CEMETERY OR CREMATORY Courter		24d. LOCATION (City, town, or county) (State) Doniphan Co Kansas

DATE REC'D BY LOCAL REG. Mar 15, 1954	REGISTRAR'S SIGNATURE Kathleen M. Allison	25. FUNERAL DIRECTOR'S SIGNATURE Virmon B. Schubert	ADDRESS Troy Mo
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(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

working under my personal supervision.

Student Embalmer No.

Signed Charles E. Bennett

Signed.....
Student Embalmer

Licensed Embalmer No. 4634

P. O. Address St. Joseph 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.