MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

853

B 18 1930

1. PLACE OF DEATH

County: Greene — Registration District No. 944 — File No. 1

Township: Jackson — Primary Registration District No. 5447B — Registered No. 1

City: ..... (No. ....., ... St. ..... Ward)

2. FULL NAME: W. F. McIntuff

(a) Residence. No. Strafford R.F.D. #2 St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: L. C. McIntuff

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec 24 1850

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
79	0	29	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN): Johnson City
(STATE OR COUNTRY): Tenn

PARENTS

10. NAME OF FATHER: Columbus McIntuff

11. BIRTHPLACE OF FATHER (CITY OR TOWN): .....
(STATE OR COUNTRY): Tenn

12. MAIDEN NAME OF MOTHER: Elizabeth Tony

13. BIRTHPLACE OF MOTHER (CITY OR TOWN): .....
(STATE OR COUNTRY): .....

14. INFORMANT: Mrs. W. F. McIntuff
(Address): Strafford Mo R.F.D. #2

15. FILED: 2/8, 1930 — A. B. Gies, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan. 23 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan. 21, 1930, to Jan. 21, 1930 that I last saw h. 1 m. alive on Jan. 21, 1930, and that death occurred, on the date stated above, at 10 - A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy

131

82 P (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Chronic Nephritis (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: .....

DID AN OPERATION PRECEDE DEATH? No — DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) O. P. H. Focht, M.D.

1/23, 1930 (Address) Strafford Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Bossville Cemetery — DATE OF BURIAL: Jan 26 1930

20. UNDERTAKER: J. W. Klingner & Co. — ADDRESS: Springfield Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.