

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. **8911**
Registrar's No. **2394**

Registration District No. **791** Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
American Hotel 6th, Market St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3**
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **Robert Shanklin McClintic**

3. (b) If veteran, name war No. _____ 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Elizabeth** 6. (c) Age of husband or wife if alive **60** years

7. Birth date of deceased **Sept. 21 1875**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 5 18 hr. min.

9. Birthplace **Marion Co. Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Refree Mo. Workmens**

11. Industry or business **Compensation Com.**

MOTHER FATHER { 12. Name **William Shields McClintic**

13. Birthplace **Virginia**
(City, town, or county) (State or foreign country)

14. Maiden name **Betty Arnold**

15. Birthplace **Virginia**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Elizabeth McClintic**

(b) Address **Monroe City, Mo.**

17. (a) **Removal** (b) Date thereof **3-12-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Monroe City, Mo.**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Ave.**

19. (a) **MAR 11 1940** (Date of death) (Registrar's signature) **J. F. Budick**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **Monroe City** **N.R.**
(If outside city or town limits, write "RURAL")
(d) Street No. **2**
(If rural, give location) _____
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar.** day **9**
year **1940** hour **10** minute **30** P.M.

21. I hereby certify that I attended the deceased from **Mar 6**, 19 **40** to **Mar 9**, 19 **40**
that I last saw him alive on **Mar 9**, 19 **40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thromboses**
Duration _____

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature **Cent. Trellis** (M. D. or other) **MO**
Address **445 No. Thaliae Bldg** Date signed **3/10/40**

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 _____, Registered Apprentice No. _____, working under my personal supervision.

Signed _____

J. G. Sullivan

Licensed Embalmer No. _____

1122

P. O. Address _____

St. Louis Mo

4700 Washington

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, above space should be left blank.