

FILED  
11-10-39  
5-17-39  
X21492

State File No. \_\_\_\_\_

Registration District No. 875

Primary Registration District No. 6162

Registrar's No. 90

1. PLACE OF DEATH:

(a) County Vermont

(b) City or town Newport ma "Rural" Wash (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital #3 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 mo 12 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) County Wash State VT

(b) County Jasper

(c) City or town Carthage (If outside city or town limits, write "RURAL")

(d) Street No. Unknown (If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Stephen Douglas McIntosh

3. (b) If veteran, name war Unknown

3. (c) Social Security No. Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 18 day March  
year 1940 hour 12:00 minute P M.

21. I hereby certify that I attended the deceased from 10-6-40  
1940, to 3-18, 1940;  
that I last saw him alive on 3-18, 1940  
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced Single

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Unknown about 75  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_

Broncho pneumonia 3 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Smoking 107W  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day

about 75 Unknown Unknown Unknown Unknown

9. Birthplace Iowa (City, town, or county) (State or foreign country)

10. Usual occupation Unknown

PHYSICIAN \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name John McIntosh

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

14. Maiden name Melinda McIntosh

15. Birthplace Unknown Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant Hospital Record

(b) Address Nevada, Mo

17. (a) Removal (b) Date thereof 3/18/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Carthage, Mo

18. (a) Signature of funeral director Carthage, Mo

(b) Address Nevada, Mo

19. (c) March 18, 1940 (b) Allen D. Ray (Registrar's signature)

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 Allen D. Ray (M. D. or other) \_\_\_\_\_

Address State Hospital #3 Date signed 3/18/40

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

RECEIVED  
District Health Officer No. 7,  
District File Number *H-410-593*  
Date Filed *H-8-40*

**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 *Mark Cechinger*  
Licensed Embalmer No. *26.56*  
P. O. Address *Nevada 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, above space should be left blank.**