DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

3811

State File No.

FILED FEB 8 1943

Registration District No. 36 5 — Primary Registration District No. 6239 Registrar's No. 5

1. PLACE OF DEATH:
(a) County: Washington
(b) City or town: Caledonia Bellewview T.S. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: R.R. 1 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days): 6 mo
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Washington
(c) City or town: Caledonia (If outside city or town limits, write "RURAL")
(d) Street No.: R.R. 1 4 miles west Caledonia (If rural, give location)
(e) If foreign born, how long in U. S. A.? — years

3. (a) PRINT FULL NAME: Nellie McIntyre
3. (b) If veteran, name war: —
3. (c) Social Security No.: None

4. Sex: F.
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: —
6. (c) Age of husband or wife if alive: — years
7. Birth date of deceased: Oct. (Month) 10 (Day) 1873 (Year)

8. AGE: Years 68 Months 11 Days 28 If less than one day ___ hr. ___ min.

9. Birthplace: East St Louis (City, town, or county) Illinois (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: Retired
MOTHER FATHER
12. Name: Dennis Murphy
13. Birthplace: Ireland (City, town, or county) (State or foreign country)
14. Maiden name: Cox
15. Birthplace: Ireland (City, town, or county) (State or foreign country)
16. (a) Informant's own signature: John Barnes
(b) Address: East St Louis, Ill.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 10 42 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt. Carmel
18. (a) Signature of funeral director: Albert H. Hoffe
(b) Address: St. Louis, Mo.
19. (a) Jan 19-43 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 8th year 1942 hour 1 minute 00 A. M.
21. I hereby certify that I attended the deceased from July 30, 1942 to Sept. 8, 1942 that I last saw h. alive on Aug. 16, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Valvular heart lesion	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death): 920	
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? (Specify type of place)
While at work? (e) Means of injury:

23. Signature: Joseph L. Kurman (M. D. or other)
Address: Potosi, Mo. Date signed: 9-9-42

810 (Licensed Embalmer's Statement on Reverse Side)

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

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.

Rev. 3-1-39 I X19511

RECEIVED
District Health Officer No. 4
District File Number 243-16
Date Filed 2-5-43

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 Albert H. Hoppe

Licensed Embalmer No. 5455

P. O. Address St. Louis, 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.

S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3811

Registration District No. 365 Primary Registration District No. 6239 Registrar's No. 5

1. PLACE OF DEATH:
(a) County: Washington
(b) City or town: Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Nellie McIntyre
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Oct (Month) 10 (Day) 1873 (Year)
8. AGE: Years 68 Months 11 Days 18 If less than one day hr. min.
9. Birthplace (City, town, or county) Ill (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) Jan 19 43 (Date received local registrar) (b) Ella White (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 8 year 1942 hour A.M. minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.
Immediate cause of death Valvular heart disease 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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY