

FILED APR 3 1943
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County... **St. Louis, Mo.**
(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: **BARNES HOSPITAL**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution...
In this community...
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town... **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4521 Chouteau Ave.**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country...

3. (a) PRINT FULL NAME **Christ A. Kintes**

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

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

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

7. Birth date of deceased... **March 25 1890**
(Month) (Day) (Year)

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

9. Birthplace... **Greece 6**
(City, town, or county) (State or foreign country)

10. Usual occupation... **Retired Restaurant Owner**

11. Industry or business

12. Name **Thomas Kintes**

13. Birthplace... **Greece 6**
(City, town, or county) (State or foreign country)

14. Maiden name... **unknown**

15. Birthplace... **Greece 6**
(City, town, or county) (State or foreign country)

16. (a) Informant **Bessie Kintes**

(b) Address **4521 Chouteau Ave.**

17. (a) **Burial** (b) Date thereof **3/29/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation... **St. Mathews Cemetery**

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

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

19. (a) **MAR 26 1943** (b) **J. F. Bredsch**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **25**
year **1943** hour **2:07** minute **07** P.M.

21. I hereby certify that I attended the deceased from **11:15 A.M.**
March 25, 1943 to **2:07 P.M. March 26, 1943**
that I last saw him alive on **March 25, 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death... **Haemorrhage + shock** Duration **5 hours**

Due to **Esophageal varix** / months

Due to **Banti's syndrome** / months

Other conditions... **1/24**
(Include pregnancy within 3 months of death)

Major findings:
Of operations...

Of autopsy **Banti's syndrome, esophageal varix, cirrhosis liver + splenomegaly**
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) (2) Means of injury...

23. Signature... **Helen Reeler** (M. D. or other)

Address **BARNES HOSPITAL** Date signed...

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.....

W. W. Wilkinson

Licensed Embalmer No.....

3570

P. O. Address.....

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.