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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 10016

ED NOV 29 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 _____

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital
Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 Days
(Specify whether years, months or days)

In this community 3 Years

3. (a) PRINT FULL NAME Robert McClintock

3. (b) If veteran, name war No

3. (c) Social Security No. _____

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced 3 divorced

6. (b) Name of husband or wife Mada

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased 11 24 1872
(Month) (Day) (Year)

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

70	11	20	hr. _____ min.
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9. Birthplace Jackson, Tenn.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired salesman

11. Industry or business _____

MOTHER FATHER

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Grace McClintock

(b) Address 3168a Iowa

17. (a) Burial (b) Date thereof 11/17/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old St. Marcus

18. (a) Signature of funeral director A. W. McLaughlin

(b) Address 2301 Lafayette Ave.

19. (a) NOV 16 1943 (b) J. F. Budick
(Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0009 17 9 24

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3169a Iowa
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 14, year 1943 hour 2:45 minute P. M.

21. I hereby certify that I attended the deceased from November 1, 1943 to November 14, 1943; that I last saw him alive on November 14, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death: Arteriosclerosis heart disease with descompensation

Due to _____

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy Refused

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)

(a) Means of injury _____

23. Signature J. L. Caryl M.D. (M. D. or other)
Address 1515 Lafayette Avenue, Date signed 11/15/43

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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..... *L.R. Casper*

Licensed Embalmer No. *2633*

P. O. Address *2317 Lafayette*

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.