

FILED MAR 11 1944

Registration District No. 1144-4

Primary Registration District No. 40634060

State File No. _____

Registrar's No. 11

1. PLACE OF DEATH:

(a) County Caldwell

(b) City or town Breakersridge
(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 _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Caldwell

(c) City or town Hamilton Mo.
(If outside city or town limits, write "RURAL")

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

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

3. (a) PRINT FULL NAME LEONARD Dewey Mc Intyre

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 13, day Jan.
year 1944 hour 7 minute 30 P. M.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Sept 19 1904
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 2, 1944, to Jan 13, 1944
that I last saw him alive on Jan 13, 1944
and that death occurred on the date and hour stated above.

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

39 3 24 hr. min.

Immediate cause of death Cerebral Thrombosis

Due to Syphilis

Duration 11 das.

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

10. Usual occupation Labourer

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.

MOTHER FATHER

12. Name Woodson S. Mc Intyre

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

14. Maiden name Myra Hamilton

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

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? _____

16. (a) Informant Mrs. Vera Butts

(b) Address Hamilton Mo.

17. (a) Burial (b) Date thereof 1 15 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Graves Mo.

18. (a) Signature of funeral director W. J. Brown

(b) Address Hamilton Mo.

19. (a) Feb 7 1944 (b) Corinna Jarrett
(Date received local registrar) (Registrar's signature)

While at work _____ (Specify type of place)

(c) Means of injury a

23. Signature J. G. Boussem (M. D. or other) D.
Address Hamilton, Mo. Date signed Jan. 14

1151

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 *Me*

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

Licensed Embalmer No. *3918*

P. O. Address *Hamilton*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 44
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Primary Registration District No. 4063 4060

Registrar's No. 11

1. PLACE OF DEATH:
(a) County Caldwell
(b) City or town Barchanridge
(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 1 rooming house
In this community 2 weeks
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Leonard D. McIntyre
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Sept 19 1900
(Month) (Day) (Year)

8. AGE: Years 29 Months 3 Days _____ (If less than one day) _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) April 3 - 1944 (b) E. A. Thompson
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
Year 1944 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis Duration 11 days

Due to Syphilis Don't know

Due to _____

Other conditions W. L. Chaffin, M.D.
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? _____

23. Signature W. L. Chaffin, M.D. (Specify type of place) _____ (e) Means of injury _____
Date signed _____

SUPPLEMENTARY

COPY CARTRIDGE BACK INK - MAKE A PERMANENT RECORD

B
3
6930

Ce-7057