

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUL 13 1944

Registration District No. 157

Primary Registration District No. 3028

Registrar's No. 141

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Carthage
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
McCune-Brooks Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 hours
(Specify whether
In this community 60 years
years, months or days)

3. (a) PRINT FULL NAME Percy Quintard

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

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mattie Quintard
6. (c) Age of husband or wife if alive - years

7. Birth date of deceased May 6 1877
(Month) (Day) (Year)

8. AGE: Years 67 Months 1 Days 10
If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business None

12. Name Frank N. Quintard

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

14. Maiden name Dena Johnson

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

16. (a) Informant Mrs. Elizabeth Belle

(b) Address Sapulpa, Oklahoma

17. (a) Burial (b) Date thereof June 20, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill Cemetery

18. (a) Signature of funeral director Knell Mortuary

(b) Address Carthage, Missouri

19. (a) June 19 '44 (b) Elizabeth Coupler
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper
(c) City or town Carthage
(If outside city or town limits, write "RURAL")
(d) Street No. 1429 Sophia
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country - - -

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 16
year 1944 hour 2 minute 30 M.

21. I hereby certify that I attended the deceased from June 10
1944 to June 16 1944
that I last saw him alive on June 16 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure
Due to Neurologic phase
use of Stomach

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 117a

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? _____

While at work? (Specify type of place) (e) Means of injury C

23. Signature T. Baker (M. D. or nurse)
Address Carthage, Mo. Date signed 6-19-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1203

44-6-537

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 Emm L. Kuep

Licensed Embalmer No. 391

P. O. Address Carthage

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.