DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 11 1944

Registration District No. 239

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38401

State File No.

Primary Registration District No. 5825

Registrar's No. 4356

1. PLACE OF DEATH:
(a) County: New Madrid
(b) City or town: Catron Mo (Comm 2) (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: None (Specify whether years, months or days)
In this community: 2 Yr. 8 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: New Madrid
(c) City or town: Catron (If outside city or town limits, write "RURAL") 72
(d) Street No. (If rural, give location) 0
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: ANDIE—MACKINTUSH
3. (b) If veteran, name war: Child
3. (c) Social Security No.
4. Sex: M
5. Color or race: White
6. (a) Single, widowed, married, divorced: 0
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Feb. (Month) 15 (Day) 1942 (Year)

8. AGE: Years 2 Months 8 Days 10 If less than one day hr. min.

9. Birthplace: Catron Mo. (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name: Orville MacKintush
13. Birthplace: Malden Mo. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Flora Jenkins
15. Birthplace: Corning Ark. (City, town, or country) (State or foreign country)
16. (a) Informant: Orville MacKintush
(b) Address: Catron Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct 26-44 (Month) (Day) (Year)
(c) Place: burial or cremation: Parma Cemetery
18. (a) Signature of funeral director: Walter Funeral Service
(b) Address: Parma Mo
19. (a) Dec 5 '44 (Date received local registrar) (b) Mrs S B Rademaker (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct, day 23, year 1944, hour 12:00 Noon, minute, M.
21. I hereby certify that I attended the deceased from Oct 23, 1944, to Oct 23, 1944, that I last saw him alive on Oct 23, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death: Malnutrition — 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)
(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: H. J. Nix (M. D. or other)
Address: Essex Mo. Date signed

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.

1028

District Health Office No. 2

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

District File Number 1244-157
State File No.
Date Filed 12-7-44

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH:

(a) County .....

(b) City or town .....
(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 ..... (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 .....

3. (b) If veteran, name war ..... 3. (c) Social Security No. .....

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

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

7. Birth date of deceased ..... (Month) (Day) (Year)

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

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
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) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month ..... day .....
year ..... hour ..... 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 ..... *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)
(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 ..... (M. D. or other) .....
Address ..... Date signed .....

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.