

No. 2
7-2-43
5-17-39
1 X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33298

FILED NOV 15 1945

State File No. _____

Registration District No. 123

Primary Registration District No. 3007

Registrar's No. 307

1. PLACE OF DEATH:

(a) County Butler

(b) City or town Poplar Bluff
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Poplar Bluff Hosp. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 days
(Specify whether _____)

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard 103

(c) City or town Bell City Route # 1 0
(If outside city or town limits, write "RURAL") 120

(d) Street No. _____
(If rural, give location) 1

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

3. (a) PRINT FULL NAME MARSHALL H. LINTZ

3. (b) If veteran, name war _____

3. (c) Social Security No. None

4. Sex Male 0 5. Color or race White

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife _____

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

7. Birth date of deceased June 16, 1912
(Month) (Day) (Year)

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

33 4 11 hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name W. M. Lintz

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

14. Maiden name Nora Bone

15. Birthplace _____ Kentucky 1
(City, town, or county) (State or foreign country)

16. (a) Informant W. M. Lintz (Father)

(b) Address Bell City, R. #1, Mo.

17. (a) Burial (b) Date thereof Oct. 25, 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bell City cemetery

18. (a) Signature of funeral director Chiles Und. Co.

(b) Address Bloomfield Mo.

19. (a) 10/3/45 (b) R. M. Minter
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 23rd
year 1945 hour 3:15 minute P M.

21. I hereby certify that I attended the deceased from Oct 12, 1945, to Oct 23, 1945;
that I last saw him alive on Oct 23, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death
Asphyxiation due to gas gangrene

Duration 5 minutes

Due to He had a gangrene
infectious of the foot

Due to Operated 12 days before he died

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations Deep foot gangrene
asphyxiation

Of autopsy 12/11

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) no

(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 _____

23. Signature Marshall H. Lintz (M.D. or other) M.D.
Address Poplar Bluff, Mo. Date signed 10-3-45

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

RECEIVED

District Health Office No. 2,

District File Number 1145-3202

Date Filed 11-3-45

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 James B. Cooper.....

Licensed Embalmer No. 4119.....

P. O. Address Bloomfield, Mo......

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.