

7. S. No. 2
ROOM-5-43
REV. 5-17-39
I X36671

FILED NOV 23 1945
318

Registration District No. Primary Registration District No. **1003**

Registrar's No. **9912**

1. PLACE OF DEATH:

(a) County **St. Louis**

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

(c) Name of hospital or institution: **Jewish Hospital 0**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **50 Yrs.** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Irene O. McIntire**

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

4. Sex **F. /** 5. Color or race **W.**

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

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

7. Birth date of deceased **July 9th., 1890**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
55	4	5	hr. _____ min.

9. Birthplace **Paris Texas /**
(City, town, or county) (State or foreign country)

10. Usual occupation **Nurse**

11. Industry or business _____

12. Name **George F. McIntire**

13. Birthplace **Mass. /**
(City, town, or county) (State or foreign country)

14. Maiden name **Lillian Brown**

15. Birthplace **Mass. /**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Rex McInitre**

(b) Address **1702 Lucas & Hunt Road**

17. (a) **Cremation** (b) Date thereof **11-16-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation **Valhalla Cemetery**

18. (a) Signature of funeral director **[Signature]**

(b) Address **3840 Lindell Blvd**

19. (a) **NOV 15 1945** (b) **J. J. Bjedek**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____

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

(d) Street No. **5561 Chamberlain Ave.** (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **14th.,**
year **1945** hour **10** minute **10 a.m.**

21. I hereby certify that I attended the deceased from **July 22**, 19**44**, to **Nov 14**, 19**45**;
that I last saw her alive on **Nov 13**, 19**45**;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Metastases to Liver	3 mo
Due to Cancer of the Breast	2 yrs
Due to _____	_____
Other conditions (Include pregnancy within 3 months of death)	_____

PHYSICIAN

Major findings: **Cancer of Breast**

Of operations _____

Of autopsy **None**

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)

_____ (e) Means of injury _____

23. Signature **E. L. Keys** (M. D. or other) **MD**

Address **6952 Maryland** Date signed **11.15.45**

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

MOTHER FATHER

20
17
9

Dr. Kemp
1952
3-11
per

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 William Matre

Licensed Embalmer No. 2825

P. O. Address 4340 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.