

No. 300
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5-17-39
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FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics
FILED SEP 13 1948

U.S. DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **22901**
7590
Registrar's No. _____

Registration District No. **310** Primary Registration District No. **1002**

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
DE PAUL HOSPITAL
(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 **St Louis**
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. **5542 JENNINGS RD.**
N.R. (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **GARNETT E. KINTZ**
3. (b) If veteran, name war _____ 3. (c) Social Security No. **496-20-9401**

4. Sex **M** 5. Color or race **W**
6. (a) Single, ~~widowed~~, married, divorced **M**
6. (b) Name of husband or wife **AGNES KINTZ**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **OCTOBER 2 1906**
(Month) (Day) (Year)

8. AGE: Years **41** Months **10** Days **25**
If less than one day _____ hr. _____ min.

9. Birthplace **ILLINOIS**
(City, town, or county) (State or foreign country)
10. Usual occupation **METAL POLISHER**

11. Industry or business _____
MOTHER FATHER {
12. Name **GEORGE E. KINTZ**
13. Birthplace **ILLINOIS**
(City, town, or county) (State or foreign country)
14. Maiden name **MAMIE ELLIS**
15. Birthplace **ILLINOIS**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Agnes Kintz**
(b) Address **5542 Jennings Rd.**
17. (a) **BURIAL** (b) Date thereof **AUG 30-48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **ST. MATTHEWS**
18. (a) Signature of funeral director **E. J. Schuur**
(b) Address **3125 Lafayette Av**
19. (a) **AUG 30 1948** (b) **J. F. Moresco**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug** day **27**
year **1948** hour **3** minute **15A** M.
21. I hereby certify that I attended the deceased from **8-25**, 19**48**, to **8-27**, 19**48**
that I last saw him alive on **8-26**, 19**48**
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Melanoma c. Generalized Metastasis
Due to **2 Possible Intestinal Obstruction**
Due to **Asp. static Pneumonia**
Other conditions _____ (Include pregnancy within 3 months of death)

PHYSICIAN _____
Major findings: Of operations _____
Of autopsy _____
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?
While at work? _____ (Specify type of place) (e) Means of injury _____
Signature **W. G. Moore** (M. D. or other) **MD**
Address **7301 Natural Bridge** Date signed **8-27-48**

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 Joseph B. Vollmer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette Ave

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.