

FILED AUG 20 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28314**
Registrar's No. **7056**

BIRTH NO. **52915-49** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Mad	
b. CITY OR TOWN St. Louis	c. LENGTH OF STAY (In this place) 0	c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony's Hospital		d. STREET ADDRESS (If rural, give location) 3973 Blaine Ave.	

3. NAME OF DECEASED (Type or Print) Infant McIntyre		4. DATE OF DEATH (Month) (Day) (Year) 8-12-49	
a. (First)	b. (Middle)	c. (Last)	
5. SEX F	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 8-12-49
9. AGE (In years last birthday)		IF UNDER 14 HRS. Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis
			12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Everett McIntyre	13b. MOTHER'S MAIDEN NAME Margie Keany	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Everett McIntyre	ADDRESS 3973 Blaine Av
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral Hemorrhage		1 day
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 1610
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? Tripped

22. I hereby certify that I attended the deceased from Aug 12, 1949 to Aug 12, 1949, that I last saw the deceased alive on Aug 12, 1949, and that death occurred at 2 PM m., from the causes and on the date stated above.

23a. SIGNATURE H. G. Moore	(Degree or title)	23b. ADDRESS 917 - 5018	23c. DATE SIGNED 8-12-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-13-49	24c. NAME OF CEMETERY OR CREMATORY St. Matthews	24d. LOCATION (City, town, or county) (State) St. Louis Missouri
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE AUG 13 1949	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS 1519 S. Grand
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

Student Embalmer No. _____

working under my personal supervision.

Not embalmed

Student
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.