

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

7759

State File No. _____

No. 300

10-48

FD MAR 11 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1747**

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri c. LENGTH OF STAY (In this place) 4 Days d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Louis City Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____ c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis d. STREET ADDRESS (If rural, give location) 1236 Temple Place	
3. NAME OF DECEASED (Type or Print) a. (First) JOHN b. (Middle) P. c. (Last) MCINTYRE		4. DATE OF DEATH (Month) (Day) (Year) FEBRUARY 13, 1953	
5. SEX M. <input checked="" type="checkbox"/> W. <input type="checkbox"/>	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 29, 1867
9. AGE (In years last birthday) 86		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 100 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (City and State or Foreign Country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME John McIntyre		13b. MOTHER'S MAIDEN NAME Bridget McNamara	
14. NAME OF HUSBAND OR WIFE Frances McIntyre		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 ADDRESS Lorraine Nicholson 1236 Temple Place	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			
MEDICAL CERTIFICATION.			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Myocardial infarction</i>		INTERVAL BETWEEN ONSET AND DEATH _____	
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) <i>Coronary Atherosclerosis</i>	
(c) <i>Pulmonary Tuberculosis</i>		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Bronchopneumonia</i>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		002X	
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) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <u>2-9-53</u> , 19 <u>53</u> , to <u>2-13-53</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>2-13-53</u> , 19 <u>53</u> , and that death occurred at <u>11:15A</u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <i>John V. Davidson M.D.</i>		23b. ADDRESS 1515 Lafayette Avenue	
23c. DATE SIGNED 2-13-53		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 2-16-53		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FEDERAL DIRECTOR'S SIGNATURE <i>Carl Smith, M.D.</i>	
DATE REC'D BY LOCAL REG. FEB 14 1953		26. FURNERAL DIRECTOR'S SIGNATURE <i>Arthur J. Donnelly</i>	

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

9.0 (Licensed Embalmer's Statement on Reverse Side)

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 me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. 4699

P. O. Address St. Charles, 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.