

FILED DEC 17 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
318

1003

State File No. 44357
Registrar's No. 11629

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. 44357		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION 4543 a, Evans Ave				e. STREET ADDRESS (If rural, give location) 4543 a, Evans Ave		2119		
3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) W. c. (Last) McIntyre			4. DATE OF DEATH (Month) (Day) (Year) 12 7 1953					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH March 1, 1876		
9. AGE (In years last birthday) 77		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 2 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Superv.			10b. KIND OF BUSINESS OR INDUSTRY Homer G. Phillips Hosp.			11. BIRTHPLACE (City and State or Foreign Country) Providence, Louisiana		
12. CITIZEN OF WHAT COUNTRY? U. S. A			13a. FATHER'S NAME Sandy McIntyre		13b. MOTHER'S MAIDEN NAME Brena Crosswhite		14. NAME OF HUSBAND OR WIFE Della McIntyre	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT'S SIGNATURE OR NAME Della McIntyre ADDRESS 4543 a. Evans Ave				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) - Congestive Heart Failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH 6 wks 2 1/2	
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) _____				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 442x				
22. I hereby certify that I attended the deceased from June 1, 1953 , to Dec. 7, 1953 , that I last saw the deceased alive on Dec 7, 1953 , and that death occurred at 3:30 PM. , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) Walter G. Young, M.D.				23b. ADDRESS 2337 Market		23c. DATE SIGNED 12/8/53		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 12/10/53		24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri		
DATE REC'D BY LOCAL REG. DEC 9 1953		REGISTRAR'S SIGNATURE F. Carl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE C. W. Roberts ADDRESS 1416 N. Taylor Ave.				

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..

Student.....
Signature of Student Embalmer

Signed *James A. Carter*

Licensed Embalmer No. *4681*

P. O. Address *St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.