No. 300
10.48

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7484

FILED MAR 3 1954

BIRTH NO. _____ REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 6TTR Registrar's No. 28

1. PLACE OF DEATH
a. COUNTY: SCOTT
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): MINER
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SIKESTON R 2

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: SCOTT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): MINER
d. STREET ADDRESS (If rural, give location): SIKESTON R 2

3. NAME OF DECEASED (Type or Print)
a. (First): BENJAMIN
b. (Middle): FRANKLIN
c. (Last): McINTOSH

4. DATE OF DEATH (Month) (Day) (Year): 2-20-1954

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: NOV 28, 1864
9. AGE (In years last birthday): 89 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10b. KIND OF BUSINESS OR INDUSTRY: Common Labor
11. BIRTHPLACE (State or foreign country): CANTON KY
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: J. W. McINTOSH
13b. MOTHER'S MAIDEN NAME: MARY
14. NAME OF HUSBAND OR WIFE: CLARA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT'S SIGNATURE OR NAME: George McIntosh — **ADDRESS**: Sikeston R 2

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic cardiovascular
DUE TO (c)

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: 4201
20. AUTOPSY? YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1-21-54, 19___, *to* 2-18-54, 19___, *that I last saw the deceased alive on* 2-18-54, 19___, *and that death occurred at* 11:05 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Albert Sargent MD
23b. ADDRESS: Sikeston, Mo.
23c. DATE SIGNED: 2-27-54

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 2-21-54
24c. NAME OF CEMETERY OR CREMATORY: City
24d. LOCATION (City, town, or county) (State): SIKESTON Mo

DATE REC'D BY LOCAL REG.: 3-1-54
REGISTRAR'S SIGNATURE: Mrs Ella Hunter 421
25. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS**: Welch Funeral Home - Sikeston Mo

(Licensed Embalmer's Statement on Reverse Side)

MAR 6

MAR 6

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 —
Student Embalmer

Signed Raymond Grewe

Licensed Embalmer No. 3467

P. O. Address Sikeston 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.