

FILED APR 18 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 12580

BIRTH NO. _____		REG. DIST. NO. <u>187</u>		PRIMARY REG. DIST. NO. <u>3040</u>		Registrar's No. <u>80</u>	
1. PLACE OF DEATH a. COUNTY <u>Livingston</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>Chillicothe</u>		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) <u>Chillicothe</u>		05920	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Chillicothe Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>Chillicothe Hospital</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>JAMES</u> b. (Middle) <u>HENRY</u> c. (Last) <u>Mc INTOSH</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April 8 1955</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>August 21, 1881</u>	
9. AGE (In years last birthday) <u>73</u>		# UNDER 1 YEAR Months _____ Days _____		# UNDER 10 HRS. Hours _____ Mins. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Hamburg, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Robert Bruce</u>			13b. MOTHER'S MAIDEN NAME <u>Emma Cowles</u>		14. NAME OF HUSBAND OR WIFE <u>Baulah I. McIntosh</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <u>Mrs. Beulah I. McIntosh Mo.</u>			
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) <u>Cerebral Vascular Accident</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive Cardiovascular Disease - Generalized Arteriosclerosis</u> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Adenocarcinoma of Prostate - Diverticular Ulcer</u>					INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>  <u>6 yrs.</u>  <u>3 yrs.</u>
19a. DATE OF OPERATION <u>26 MAR 55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Adenocarcinoma of Prostate</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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?			
22. I hereby certify that I attended the deceased from <u>25 MAR</u> , 19 <u>55</u> , to <u>8 APRIL</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7 APRIL</u> , 19 <u>55</u> , and that death occurred at <u>12:00 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>J. A. Martin M.D.</u>				23b. ADDRESS <u>Chillicothe Mo.</u>		23c. DATE SIGNED <u>9/11/55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4-9-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Meadville Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Meadville, (Linn) Mo.</u>	
DATE REC'D BY LOCAL REG. <u>4-9-55</u>		REGISTRAR'S SIGNATURE <u>Frances B Nail</u>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>NORMAN FUNERAL HOME; Chillicothe, Mo</u>			

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

APR 2 1938

**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 Edwin F. Norman

Licensed Embalmer No. 4036

P. O. Address Chillicothe, 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.