

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12388

STATE FILE NUMBER

FILED APR 29 1957

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 230

Health,
& Welfare
Public
Service

S. 300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>CAPE GIRARDEAU</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SCOTT</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <u>CAPE GIRARDEAU</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>CHAFFEE</u> Inside Limits <u>1000</u> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>RFD #1</u>		Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>CAPE OSTE. HOSP 26 DAYS</u> Length of stay in lb				4. DATE OF DEATH Month Day Year <u>APR. 15-1957</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES ARTHUR MCINTOSH</u>			9. AGE (In years last birthday) <u>71</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>6 11</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 4-1885</u>			
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>FARM</u>	11. BIRTHPLACE (City and state or country) <u>HARRISBURG ILL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES MCINTOSH</u>				14. MOTHER'S MAIDEN NAME <u>MELINDA SIMMONS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mr. Nellie McIntosh</u> Address <u>CHAFFEE MO</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>27 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <u>Auricular Fibrillation</u> <u>unknown</u>	
						DUE TO (c) <u>Hypostatic Pneumonia</u> <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4201</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>3-20-57</u> to <u>4-15-57</u> and last saw ^{her} _{him} alive on <u>4-15-57</u> . Death occurred at <u>4:40 p.m.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>R. M. Stevenson, D.O.</u>				22b. ADDRESS <u>High Bldg. Cape Girardeau Mo</u>		22c. DATE SIGNED <u>4-21-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>4-17-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>UNION PARK GEN. CHAFFEE MO</u>		23d. LOCATION (City, town, or county) (State) <u>CHAFFEE MO</u>		
24. FUNERAL DIRECTOR ADDRESS <u>STUBBS FUNERAL HOME</u>			25. DATE RECD. BY LOCAL REG. <u>4-22-1957</u>		26. REGISTRAR'S SIGNATURE <u>(C. C. Summers)</u>		

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(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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Eugene L. Stuhler*.....

Licensed Embalmer No. *501*.....

P. O. Address *Chaffee, 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.