

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023328

STATE FILE NO. 6228  
REGISTRATION DISTRICT NO. 2

C-18 096 948

SL 98

FILED JUL 13 1959

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>ST. LOUIS, MO.</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VET. ADM. HOSPITAL</b>		Length of stay in lb <b>6 DAYS</b>	d. STREET ADDRESS (If outside, give location) <b>1071 BADEN AVE.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>EARL</b> Middle <b>A.</b> Last <b>RINTOUL</b>			4. DATE OF DEATH Month <b>JUNE</b> Day <b>30</b> Year <b>1959</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 6, 1895</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WATCHMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>64</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.
11a. FATHER'S NAME <b>WILLIAM A. RINTOUL</b>		11b. BIRTHPLACE (City and state or country) <b>DOM, ILLINOIS</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>WILLIAM A. RINTOUL</b>		13b. MOTHER'S MAIDEN NAME <b>SARAH WHITE</b>	14. NAME OF HUSBAND OR WIFE <b>CECILIA RINTOUL</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW-1</b>		16. SOCIAL SECURITY NO. <b>492-10-9868</b>	17. INFORMANT Address <b>VAH, 915 N. GRAND AVE., ST. LOUIS, MO.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MASSIVE SUBDURAL HEMORRHAGE, RIGHT WITH COMPRESSION OF CEREBRUM</b> DUE TO (b) <b>THROMBOCYTOPENIA, (SUSPECTED SECONDARY TO LEUKEMIA) COMPLICATED BY HEAD TRAUMA</b> DUE TO (c) <b>LEUKEMIA, SUSPECTED</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <b>NONE <input type="checkbox"/></b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>2044 F</b>	
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.		20d. INJURY OCCURRED WHILE AT <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. attended the deceased from <b>6-24-59</b> to <b>6-30-59</b> and last saw him alive on <b>6-30-59</b> Death occurred at <b>12:00AM</b> on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <b>Harold Sandstead M.D.</b>	
22b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>		22c. DATE SIGNED <b>6-30-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7-3-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>John Stygar &amp; Son 5541 Riverview Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>JUL 1 '59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>

ALL DISSEMINATED BY THE DIVISION OF HEALTH OF MISSOURI  
 DR. HAROLD SANDSTEAD SAID HE CLEARED AUTOPSY PERMISSION THROUGH  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. CORONERS OFFICE

Health, Welfare, Public Service  
 34  
 300  
 1-57  
 891

MEDICAL CERTIFICATION

ad  
 Dr. Harold Sandstead  
 July 1-59

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 *J. W. Rister* .....

Licensed Embalmer No. *3480* .....

P. O. Address. *At Lewis 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.