

# MORTUARY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037835

FILED VS. OCT 21 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's **2 9284** STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b> Length of stay in 1b _____		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____  c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>5800 Arsenal St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis Chronic Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Frank W. McIntire (also known as) Frank W. McIntyre</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>October 6, 1959</b>		
<b>5. SEX</b> Male	<b>6. COLOR OR RACE</b> White	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>9/21/1881</b>	<b>9. AGE</b> (last birthday) 78	IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HR Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Retired Foreman		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> Shoe Factory		<b>11. BIRTHPLACE</b> (City and state or country) Palmyra, Mo.	
<b>12. CITIZEN OF WHAT COUNTRY</b> U.S.		<b>13a. FATHER'S NAME</b> Ezekial McIntire		<b>13b. MOTHER'S MAIDEN NAME</b> Sarah Warren	
<b>14. NAME OF HUSBAND OR WIFE</b> Ada		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) No		<b>16. SOCIAL SECURITY NO.</b> 486-14-4826	
<b>17. INFORMANT</b> Harold R. McIntire, 2916 S.E. 19th St.		<b>17. ADDRESS</b>			

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i> Generalized Arteriosclerosis DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 420.0	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)		
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____						
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE		

21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
 Death occurred at \_\_\_\_\_ on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <i>Patrick Taylor Carver</i>		<b>22b. ADDRESS</b> 1300 Clark		<b>22c. DATE SIGNED</b> 10-9-59	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> Removal		<b>23b. DATE</b> 10-10-59		<b>23c. NAME OF CEMETERY OR CREMATORY</b> Memorial Park Cemetery	
<b>23d. LOCATION</b> (City, town, or county) St. Louis Co., Mo.		<b>24. FUNERAL DIRECTOR</b> ADDRESS Albert H. Hoppe, Inc., 4700 Washington Blvd.		<b>25. DATE RECD. BY LOCAL REG.</b> OCT 9 '59	
<b>26. REGISTRAR'S SIGNATURE</b> <i>Harold Smith, M.D.</i>					

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed W. W. Wilkinson

Licensed Embalmer No. 357

P. O. Address 14 Four

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.