

**URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-042196**

**FILED VS NOV 20 1959**

**210430**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's 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>IRON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>915 N GRAND ST LOUIS MO</b>		Length of stay in 1b <b>30HRS 15MIN</b>	c. CITY OR TOWN <b>ARCADIA</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>VETS ADMIN HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>JESSE</b> Middle <b>H.</b> Last <b>MC INTOSH</b>			4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>10</b> Year <b>1959</b>	
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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>1/10/72</b>	9. AGE (last birthday) <b>87</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DOCTOR OF MEDICINE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>GENERAL PRACTICE</b>	11. BIRTHPLACE (City and state or country) <b>WHITE CNTY. ILL.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>JAMES MC INTOSH</b>	13b. MOTHER'S MAIDEN NAME <b>NANCY HENDRICKS</b>	14. NAME OF HUSBAND OR WIFE <b>LILLIAN E MC INTOSH</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>YES</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT Address <b>VA HOSP RECORDS 915 N GRAND ST LOUIS MO</b>
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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>CORONARY ARTERY THROMBOSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 YEARS</b>
DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		
DUE TO (c) <b>420.0</b>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>PERICARDITIS</b>	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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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____
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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 _____
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21. I attended the deceased from **11/9/59** to **11/10/59** and last saw him alive on **11/10/59**  
Death occurred at **3:40 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>JOHN M BARY</b> (Degree or title) <b>M.D.</b>	22b. ADDRESS <b>VAH, ST LOUIS, MISSOURI</b>	22c. DATE SIGNED <b>11/10/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11-14-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Godfrey Township, Ill.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Smith Funeral Home, 2521 Edwards, St. Alton, Ill</b>	25. DATE RECD. BY LOCAL REG. <b>NOV 12 1959</b>	26. REGISTRAR'S SIGNATURE <b>Coart Smith, M.D.</b>
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BY AFFIDAVIT OF **Dr. Bary** 30 hrs. DOCUMENT MEDICAL CERTIFICATION

**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  \_\_\_\_\_

Licensed Embalmer No. 6119

P. O. Address 205 Brown

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.