

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-025337

3573

STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

FILED AUG 8 1961

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Kansas City</b>           |  | Length of stay in lb<br><b>16 yrs. Life</b>  | c. CITY OR TOWN <b>Kansas City</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>VA Hospital</b> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location)<br><b>3114 Euclid</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>GEORGE ROBERT MC INTYRE.</b> |  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>JULY 15, 1961</b> |  |  |
|---|--|--|--|--|--|

|                       |                                  |   |                                    |                                     |   |                              |
|-----------------------|----------------------------------|---|------------------------------------|-------------------------------------|---|------------------------------|
| 5. SEX<br><b>Male</b> | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>4-25-94</b> | 9. AGE (last birthday)<br><b>67</b> | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HR<br>Hours Min. |
|-----------------------|----------------------------------|---|------------------------------------|-------------------------------------|---|------------------------------|

|  |  |   |   |
|--|--|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Bread Salesman</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Baking</b> | 11. BIRTHPLACE (City and state or country)<br><b>Kansas City, Mo.</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b> |
|--|--|---|---|

|   |   |  |
|---|---|--|
| 13a. FATHER'S NAME<br><b>John Mc Intyre</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Sadie Stockdale</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Louise M. Mc Intyre.</b> |
|---|---|--|

|  |   |
|--|---|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>Yes WWI</b> | 17. INFORMANT <b>Louise M. Mc Intyre</b><br><b>VA Hospital Records 3114 Euclid, K.C. Mo</b> |
|--|---|

|  |  |                                  |
|--|--|----------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY: |  | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <b>TRACHEOBRONCHIAL ASPIRATION OF GASTRIC CONTENTS</b>                               |  |                                  |
| DUE TO (b) <b>CORONARY INSUFFICIENCY</b>   |  |                                  |
| DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS, MARKED</b>   |  |                                  |

|  |  |  |
|--|--|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>CYSTIC ENCEPHALEMALACIA, LEFT.</b> |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
|--|--|--|

|  |   |  |
|--|---|--|
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input 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<br>Hour a.m. p.m.<br>Month, Day, Year | 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<br>COUNTY STATE |
|---|--|--|--|

|  |
|--|
| 21. I attended the deceased from <b>7-5-61</b> to <b>7-15-61</b> and <del>was present</del><br>Death occurred at <b>2:00 pm</b> on the date stated above, and to the best of my knowledge, from the causes stated. |
|--|

|   |  |                                    |
|---|--|------------------------------------|
| 22a. SIGNATURE<br><i>[Signature]</i><br>(Degree or title)<br><b>M. D.</b> | 22b. ADDRESS<br><b>VA Hospital, Kansas City, Mo.</b> | 22c. DATE SIGNED<br><b>7-16-61</b> |
|---|--|------------------------------------|

|  |                                   |  |  |
|--|-----------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 23b. DATE<br><b>July 18, 1961</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Moriah Cemetery</b> | 23d. LOCATION (City, town, or county) (State)<br><b>Kansas City Missouri</b> |
|--|-----------------------------------|--|--|

|   |  |   |
|---|--|---|
| 24. FUNERAL DIRECTOR<br><b>D.W. Newcomer's Sons, Kansas City, Mo.</b> | 25. DATE RECD. BY LOCAL REG.<br><b>7-18-61</b> | 26. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |
|---|--|---|

DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ

**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 Harold P. Reich

Licensed Embalmer No. 4998

P. O. Address Kansas City

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.