

X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9459

State File No.

FILED APR 7 1943

Registration District No. 100

Primary Registration District No. 3002

Registrar's No. 51

1. PLACE OF DEATH:

(a) County Audrain
(b) City or town Mexico
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
None / 617 Woodlawn
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community Life (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Audrain
(c) City or town Mexico (If outside city or town limits, write "RURAL")
(d) Street No. 617 Woodlawn (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Holla M. McIntire

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M /

6. (b) Name of husband or wife Nell Landon 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased Jan. 1, 1877
(Month) (Day) (Year)

8. AGE: Years 66 Months 0 Days 28 If less than one day hr. min.

9. Birthplace Mexico, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Publisher

11. Industry or business Missouri Printing Co.

12. Name W. B. McIntire

13. Birthplace Ill.
(City, town, or county) (State or foreign country)

14. Maiden name Sarah W. Criswell

15. Birthplace Mexico, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Nell McIntire

(b) Address Mexico, Missouri

17. (a) Burial (b) Date thereof 3/28/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood

18. (a) Signature of funeral director Wm. L. Lindsey

(b) Address Mexico, Missouri

19. (a) 3/25/43 (b) Margaret H. Mackie
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 25 year 1943 hour 5 minute P M.

21. I hereby certify that I attended the deceased from Oct. 1941 to March 25, 1943
that I last saw him alive on March 25, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Dilatation of heart & Hypertension & cerebral hemorrhage & nephritis Duration

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations..... Of autopsy..... PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work (Specify type of place) (A) Means of injury
23. Signature Fred Luffin (M. D. or other) MD
Address Mexico, Mo Date signed 3/27/43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

MAY 15 1943

RECEIVED

District Health Officer No. 10

District File Number 4-43-626

Date Filed MAR 15 1943

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed [Handwritten Signature]

Licensed Embalmer No. 3569

P. O. Address Mexico, 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 this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9459
Registrar's No. 51

Registration District No. 10

Primary Registration District No. 3002

1. PLACE OF DEATH:

(a) County Andran
(b) City or town Mexico
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Rella M Mcdonut

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 1 1943
(Month) (Day) (Year)

8. AGE: Years 66 Months 3 Days 1 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry of business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 1 Year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death acute dilation of heart Duration _____

Due to hypertension of cerebral hemorrhage

Due to nephritis

Other conditions Chronic Nephritis

(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

13/8

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____ Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

PHYSICIAN
Underline the cause to which death should be charged statistically.

EX-101 5-1-1971