

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

ED AUG 9 1943

Registration District No. 243

Primary Registration District No. 4364

Registrar's No. 18

1. PLACE OF DEATH:

(a) County Newton

(b) City or town Stella
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Cardwell Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County McDonald

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Goodman MO R.F.D. No. 17
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Martin Luther McIntire

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

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Bertha McIntire

6. (c) Age of husband or wife if alive 28 years

7. Birth date of deceased Sept, 18th, 1908
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

| | | | |
|----|----|---|----------------------|
| 34 | 10 | 0 | _____ hr. _____ min. |
|----|----|---|----------------------|

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

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER {

12. Name W.E. McIntire

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

14. Maiden name Mable Berry

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

16. (a) Informant W.E. McIntire

(b) Address _____

17. (a) Burial _____ (b) Date thereof 7-20-1943
(Burial, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anderson MO

18. (a) Signature of funeral director Charles Williams

(b) Address Goodman MO

19. (a) 8-3-43 (b) Alphonse H. Dyer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 18th
year 1943 hour 4 minute 20P. M.

21. I hereby certify that I attended the deceased from July 14 1943 to July 18 1943
that I last saw him alive on July 18 1943
and that death occurred on the date and hour stated above.

Immediate cause of death: Ruptured gangrene appendix - peritonitis

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Ruptured gangrene appendix

Of operations _____

Of autopsy _____

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 D

23. Signature: Cardwell (M. D. or other)

Address: Stella Mo. Date signed: 7-27-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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0
0

1317

RECEIVED

8-6-43

District Health Officer No.

District File Number

843-155

Date Filed

8-7-43

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SEP 10 1945

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.....

Licensed Embalmer No.....

P. O. Address.....

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.