. S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 6256

FILED MAR 6 1945

Registration District No. 6

Primary Registration District No. 4221

Registrar's No. 13

14
1
0

1. PLACE OF DEATH:

(a) County: Holt

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

(c) Name of hospital or institution: 1

(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) In this community: 60 Yrs.

2. USUAL RESIDENCE OF DECEASED: 44

(a) State: Missouri (b) County: Holt

(c) City or town: Mound City. (If outside city or town limits, write "RURAL") 0

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No) No.

If yes, name country

3. (a) PRINT FULL NAME: Fredrick Lyman McIntire.

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: Male 0

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married. 1

6. (b) Name of husband or wife: Hazel McIntire.

6. (c) Age of husband or wife if alive: 57 years

7. Birth date of deceased: March 2nd. 1884. (Month) (Day) (Year)

8. AGE: Years 60 Months 11 Days 14 If less than one day hr. min.

9. Birthplace: Maitland Mo. (City, town, or county) 0 (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business:

MOTHER FATHER

12. Name: V. S. McIntire.

13. Birthplace: Mo. (City, town, or county) 0 (State or foreign country)

14. Maiden name: Amanda Marion.

15. Birthplace: Missouri. (City, town, or county) 0 (State or foreign country)

16. (a) Informant: Sam Smith

(b) Address: Mound City. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2/19/45 (Month) (Day) (Year)

(c) Place: burial or cremation: Mound City. Mo.

18. (a) Signature of funeral director: H. Lawson

(b) Address: Mound City. Mo.

19. (a) Feb. 19-1945 (Date received local registrar) (b) Pauline Lawson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Feby. day: 16 year: 1945 hour: 10 minute: P. M.

21. I hereby certify that I attended the deceased from Feb 16-45 to Feb 16, 1945 that I last saw him alive on Feb 16, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage — Duration: 3 hrs

Due to: 1

Due to: 2

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

Major findings: Of operations: 4

Of autopsy: 5

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? (Specify type of place)

While at work? (e) Means of injury: 0

23. Signature: D. O. Perryman (M. D. or other) MD

Address: Mound City Mo. Date signed: 2-19-45

1185

(Licensed Embalmer's Statement on Reverse Side)

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 [signature]

Licensed Embalmer No. 1824

P. O. Address Maund City 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.