

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

JAN 21 1929

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

39554

1. PLACE OF DEATH

County Richman Registration District No. 85 File No. _____
Township Washington Primary Registration District No. 1001 Registered No. 1475
City St Joseph (No. 604 North 10th St. _____ Ward)

2. FULL NAME

Robert Helen McBain
(a) Residence. No. 604 No. 10th St., _____ Ward. _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 11 mos. 27 ds. How long in U.S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 29 1879

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
48 11 27

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) St Joseph
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Benjamin P. McBain

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Niles
(STATE OR COUNTRY) Michigan

12. MAIDEN NAME OF MOTHER Quintilla Hunter

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Chickering
(STATE OR COUNTRY) Ohio

14. INFORMANT Mrs Quintilla McBain
(Address) 604 No. 10th St. St. Joseph Mo.

15. FILED 27 1928
J. M. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 26 1928

17. Viewed body
I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. er. alive on _____, 19____, and that death occurred, on the date stated above, at _____, 3 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral Insufficiency

92A
90 W
CONTRIBUTORY (SECONDARY) _____
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) J. W. Tullock Coroner, M. D.
12/27, 1928 (Address) St Joseph Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St. Moral Cemetery DATE OF BURIAL Dec 28 1928
20. UNDERTAKER E. G. Sidenfaden ADDRESS 602 So. 10

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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