

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

Do not use this space.

12647

1. PLACE OF DEATH

County.....

Registration District No. **791**

1003

Township.....

Primary Registration District No.

City **St. Louis, Mo.** (No. **City Dept.**)

File No.

Registered No. **3180**
St. Ward)

2. FULL NAME

Dorothy McBride

(a) Residence No. **2220 So. 3rd** St. **213** Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

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 OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **March 3-1921**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
8 **0** **9**

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Lafayette**
(b) General nature of industry, business, or establishment in which employed (or employer) **School**
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **St. Louis Mo.**
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER **Arthur W. McBride**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Ill.**
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Olya Wirtz**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **St. Louis Mo.**
(STATE OR COUNTRY)

14. INFORMANT **Arthur W. McBride**
(Address) **4449 So. 3rd St.**

15. FILED **Mar 10 1929** **Mar 10 1929**
19. **Mar 10 1929**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **March 11 1929**

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at..... **3:55 P.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho Pneumonia
107A

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

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

DID AN OPERATION PRECEDE DEATH..... DATE OF.....
WAS THERE AN AUTOPSY? **yes**

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **J. W. Kerns, M.D.**
3/13, 19**29** (Address) **Coroners Office**

*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 **New St. Marcus** DATE OF BURIAL **3-15-1929**

20. UNDERTAKER **Ziegenhein Bros. 2623 Cherokee** ADDRESS

PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION is very important. INFORMATION about CAUSE OF DEATH in plain terms, so that

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Louis
 Township St. Louis
 City St. Louis (No.)

Registration District No. 791
 Primary Registration District No. 1003

File No.
 Registered No. 3180
 St. Ward

2. FULL NAME

(a) Residence. No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (or) WIFE of

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
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8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
 (STATE OR COUNTRY)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT
 (Address)

15.

FILED - 6, 1929
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/12 1929

17. I HEREBY CERTIFY That I attended deceased from 19..... to 19.....
 that I last saw him alive on 19....., and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Bronchitis Pneumonia
Primary
 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) 1000
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. W. Ferner, M.D.

5/22 1929 (Address) Dep. Corner
 *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 DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

Every item of information should be stated EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. CAUSE OF DEATH should be clearly classified. Exact statement of OCCUPATION is very important. REGISTER - ALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LA.

SUPPLEMENTARY

S-12647