

SEP 20 1935

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

Do not use this space.

25589

1. PLACE OF DEATH

County Boone
Township Rockyfork
City Hallsville

Registration District No. 74
Primary Registration District No. 4042

File No. _____
Registered No. 8
St. _____ Ward _____

2. FULL NAME

David L. McBride

(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 3 yrs. mos. _____ ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Mrs. Lattie McBride</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Aug 11 - 1854</u>		
7. AGE YEARS <u>81</u>	MONTHS <u>0</u>	DAYS <u>9</u>
		If LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Retired Farmer</u>		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation

OCCUPATION

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 20, 193522. I HEREBY CERTIFY, That I attended deceased from March, 1930, to Aug 20, 1935I last saw him alive on Aug 20, 1935. Death is saidto have occurred on the date stated above, at 8:30 p. m.

The principal cause of death and related causes of importance were as follows:

Chronic BronchitisDate of onset
1930

Other contributory causes of importance:

Name of operation _____ Date of _____
What test confirmed diagnosis? no Was there an autopsy? no23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____Where did injury occur? _____
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.Manner of injury _____
Nature of injury _____24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____(Signed) C. B. Lawrence, M. D.
(Address) Hallsville Mo.

FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>
	13. NAME <u>Jed McBride</u>
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>
	15. MAIDEN NAME <u>Nancy Walker</u>
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>
17. INFORMANT (ADDRESS) <u>Mrs. Lattie McBride</u>	
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Church of Christ</u> DATE <u>Aug 22</u> , 19 <u>35</u>	
19. UNDERTAKER (ADDRESS) <u>H. L. Shook</u> <u>Hallsville Mo.</u>	
20. FILED <u>8/21</u> , 19 <u>35</u> <u>Mrs. F. L. Lawrence</u> Registrar.	

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.

