

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.

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

Do not use this space.

NOV 21 1935

29760

1. PLACE OF DEATH *Jackson* Registration District No. *333*
County *Jackson* Primary Registration District No. *333*
Township *Ran* City *Ran City* (No. *Helping Hand*) St. _____ Ward) _____
2. FULL NAME *James M E Bride*
(a) Residence, No. *Helping Hand* 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. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Single</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Jan 26 - 1891</i>		
7. AGE	YEARS <i>44</i>	MONTHS <i>8</i>
	DAYS <i>2</i>	If LESS than 1 day, _____ hrs or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>operator</i>	
	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
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Mo.</i>		
FATHER	13. NAME <i>Samuel B. McBride</i>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Ill.</i>	
MOTHER	15. MAIDEN NAME <i>May Matthews</i>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Ill.</i>	
17. INFORMANT <i>Miss Mrs Bride</i> (ADDRESS) <i>Jackson, Mo.</i>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Jackson, Mo</i> DATE <i>9-30-35</i>		
19. UNDERTAKER <i>Olemonit - Wood</i> (ADDRESS) <i>Jackson, Mo</i>		
20. FILED <i>10/1</i> 19 <i>35</i> M. M. <i>Corwin</i> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept 28 1935*

22. I HEREBY CERTIFY That I attended deceased from _____, 19____
I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____, Mo.
The principal cause of death and related causes of importance were as follows:
Cholelithiasis
Date of onset _____

Other contributory causes of importance:
NO

Name of operation _____ Date _____
What test confirmed diagnosis _____ Was there an autopsy? _____

23. 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 of the deceased any related to occupation of deceased? _____
If so, specify _____
(Signed) *[Signature]*, M. D.
(Address) _____

