

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

21770

State File No.

Registrar's No.

Registration District No. 318

Primary Registration District No. 2001

546

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
907 N. ROGERS
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days 2 mo

3. (a) PRINT FULL NAME WILLIAM J. McBRIDE

3. (b) If veteran, name war none 3. (c) Social Security No. NO.

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Veda McBride 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased 11 / 1870
(Month) (Day) (Year)

8. AGE: Years 69 Months 7 Days 16 If less than one day _____ min.

9. Birthplace Unknown Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Sheet Metal Worker

11. Industry or business R. R. Shops

12. Name John G. McBride

13. Birthplace Unknown Tenn.
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Veda McBride
(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof June 30-1940
(Burial, cremation, or removal) (Month) (Day) (Year)
East Lawn Cemetery

18. (a) Signature of funeral director W. E. Handley
(b) Address Springfield, Mo.

19. (a) June 27, 1940 (b) W. E. Handley
(Date received from registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 907 N. Rogers
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 27th
year 1940 hour 8 minute 35 A. M.

21. I hereby certify that I attended the deceased from Apr. 1939
June 27, 1940,
that I last saw him alive on June 26, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 10 days

Due to Paralysis Agitans 10 yrs
Arteriosclerosis " "

Due to None

Other conditions (Include pregnancy within 3 months of death) None

Major findings: Of operations None

Of autopsy None

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?
907 N. Rogers (Specify type of place) (e) Means of injury _____

23. Signature J. Newton Walker (M. D. or other) _____
Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

9
3
6

5

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.....

J. B. Klengner

Licensed Embalmer No. 3358

P. O. Address.....

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, above space should be left blank.

X