. S. No. 2
1—11-10-39
ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Ro 0510

FILED JUN 6 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 18994

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 1000

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis, Missouri Lemay
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Mt. St. Rose Sanatorium
(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. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County 999

(c) City or town Red Bud 11
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 2 years.

3. (a) PRINT FULL NAME LAURA, SISTER M. (McBRIDE)

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife Single

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec. (Month) 20 (Day) 1914 (Year)

8. AGE: Years 26 25 | Months 4 11 | Days 19 | If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Teacher

11. Industry or business

FATHER
12. Name Arthur McBride
13. Birthplace Prairie DeRocher (City, town, or county) Ill. (State or foreign country)

MOTHER
14. Maiden name Laura Hayden
15. Birthplace Prairie DeRocher (City, town, or county) Ill. (State or foreign country)

16. (a) Informant Sister M Vincentia

(b) Address Red Bud Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-10-41 (Month) (Day) (Year)

(c) Place: burial or cremation Red Bud, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Av.

19. (a) MAY 10 1941 (Date received local registrar) (b) R. R. Meyer M.D. Dr. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 9
year 41 hour 10 minute 40 A.M.

21. I hereby certify that I attended the deceased from 7/5/, 1939, to 5/9/, 1941;
that I last saw her alive on 5/8/, 1941;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Air embolism	1 minute
Due to Surgical Operation	30 minutes
Due to Pulmonary tuberculosis	2 yrs
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy Confirmed Diagnosis.

PHYSICIAN
Underline the cause to which death should be charged statistically.

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? _____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature [signature] (M. D. or other)

Address 46 E. Jo. Taylor Date signed 5/9/41

(Licensed Embalmer's Statement on Reverse Side)

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 Albert W. Hampe

Licensed Embalmer No. 1861

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.