S. No. 2
—1-4-41
5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17877

FILED JUN 3 1943

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 377

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

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: St. Johns HOSPITAL (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: 39

(a) State Missouri (b) County Greene

(c) City or town Strafford ~~Route 2~~ (If outside city or town limits, write "RURAL")

(d) Street No. Rural Route 2 (If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country /

3. (a) PRINT FULL NAME Charles Edward McBride

3. (b) If veteran, name war None

3. (c) Social Security No. NONE

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Infant

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

7. Birth date of deceased March (Month) 20 (Day) 1943 (Year)

8. AGE: Years 0 Months 1 Days 18 If less than one day ..... hr. ..... min.

9. Birthplace Springfield (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Infant

11. Industry or business Infant

FATHER
12. Name Clarence Eugene McBride
13. Birthplace Unknown (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Marie Walker
15. Birthplace Unknown (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Clarence Eugene McBride

(b) Address Strafford Route 2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 9, 43 (Month) (Day) (Year)

(c) Place: burial or cremation St. Marys Cemetery

18. (a) Signature of funeral director J. W. Klingner&Co.

(b) Address Springfield, Mo.

19. (a) 5-8-43 (Date received local registrar) (b) D W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8 year 1943 hour 6;00 minute A.M.

21. I hereby certify that I attended the deceased from 5-1, 1943, to 5-8, 1943 that I last saw her alive on ....., 19..... and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Congen malformation of heart	life
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy Patent ductus arteriosus
Malformation of left ventricle

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 Springfield, Mo Date signed 5-8-43

(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 .....

Licensed Embalmer No. .....

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.