

V. S. No. 2  
FORM-8-43  
Rev. 5-17-39  
K 37823

3486

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 2863

FILED FEB 13, 1945

Registration District No. 317

Primary Registration District No. 6076

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

36  
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1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Koch  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Robert Koch Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 422 days  
(Specify whether)

In this community same 0  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Overland  
(If outside city or town limits, write "RURAL")

(d) Street No. 1909<sup>th</sup> Nodimont  
(If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME William Jennings McBee

3. (b) If veteran, name war None

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 22  
year 1945 hour 2 34 minute 17 PM

21. I hereby certify that I attended the deceased from November 19, 1943, to JAN. 22, 1945;  
that I last saw him alive on JAN. 22, 1945;  
and that death occurred on the date and hour stated above.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Little McBee

6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased March 7, 1897  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_

Due to Pulmonary Tuberculosis 3 1/2 yrs?

8. AGE:

Years	Months	Days	If less than one day
<u>47</u>	<u>10</u>	<u>15</u>	<u>-</u> hr. <u>-</u> min.

Due to \_\_\_\_\_

Other conditions Syphilitic heart disease  
(Include pregnancy within 3 months of death)

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

10. Usual occupation Factory worker

11. Industry or business \_\_\_\_\_

12. Name Andrew McBee

13. Birthplace Newton Co. Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Florence Beecher

15. Birthplace ? Tennessee  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy 302

16. (a) Informant Patient's hospital record

(b) Address Robert Koch Hospital

17. (a) BURIAL (b) Date thereof 1-25-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lake Charles Cem.

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury 0

Signature P Engelman, M.D. (M. D. or other)

Address Koch Missouri Date signed 1-22-45

18. (a) Signature of funeral director ORTMANN FUNERAL HOME

(b) Address 9222 LACKLAND OVERLAND MO

19. (a) JAN 24 1945 (b) E. H. McElwain, M.D.  
(Date received local registrar) (Registrar's signature)

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**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 Al C Ostmann

Licensed Embalmer No. 3478

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, fact should be so stated above.**