

No. 2
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17-39
X35837

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4528

FILED MAR 14 1945 818

1003

State File No. _____

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2015

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Enroute to City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____ years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1012 Hodiament
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME George Leslie McBride

3. (b) If veteran, name war Unknown 3. (c) Social Security No. None

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

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

7. Birth date of deceased About 1873
(Month) (Day) (Year)

8. AGE: Years About 72 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Unknown Ireland 4
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Insurance Investigator

11. Industry or business _____

MOTHER FATHER

12. Name Joseph M. McBride
13. Birthplace Unknown Ireland 4
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Leslie
15. Birthplace Unknown Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Lucy McBride
(b) Address 2625 Chaucer Ave.

17. (a) Burial (b) Date thereof 3-2-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation FeeFee Cemetery

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) MAR 1 1945 (Date received local registration) J. F. Brudick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 27
year 1945 hour 12 minute 10 P. M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____;

that I last saw him _____ alive on _____, 19____ and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Coronary Sclerosis

Due to Arteriosclerosis

Due to 9/14

Other conditions _____ (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____
Of operations _____
Of autopsy _____
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? _____

While at work? _____ (Specify type of place)
(c) Means of injury _____

23. Signature Dr. Alfred J. Perry 3 (M. D. or other)
Address Deputy Coroner Date signed 3-1-45

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

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 G. Haffner*

Licensed Embalmer No. *2971*

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.