

No. 2
M-5-43
5-17-39
I X36671

FILED NOV 21 1946
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State File No.

Registration District No.

Primary Registration District No. 5465

Registrar's No. 876

1. PLACE OF DEATH: **GREENE**

(a) County **GREENE**

(b) City or town **Rural-2nd. N. Campbell**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
R. F. D. #5
(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 **Missouri** (b) County **Greene 37**

(c) City or town **Rural * Springfield**
(If outside city or town limits, write "RURAL")

(d) Street No. **R. F. D. #5**
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME **Robert Earl McBride**

3. (b) If veteran, name war **No**

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 **Fay**

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

7. Birth date of deceased **October 6 1875**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

71 0 26 hr. min.

9. Birthplace **Manchester, Iowa**
(City, town, or county) (State or foreign country)

10. Usual occupation **Manufacturer**

11. Industry or business **Wood Novelties**

MOTHER FATHER

12. Name **John McBride**

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

14. Maiden name **Mitchell**

15. Birthplace **New York**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Fay McBride**

(b) Address **R. F. D. #5**

17. (a) **Burial** (b) Date thereof **Nov. 4 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Maple Park**

18. (a) Signature of funeral director **Klingner Funeral**

(b) Address **424 E. Com'l - Spgd., Mo.**

19. (a) **11-4-46** (b) **H. Handley MD**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **2**
year **1946** hour **12** minute **15 A.M.**

21. I hereby certify that I attended the deceased from **June 3**
1946 to **Nov 1** 19**46**
that I last saw him alive on **Nov 1** 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Respiratory failure
Bulbar Paralysis**

Duration _____

Due to _____

Due to _____

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

Major findings: **82**

Of operations _____

Of autopsy _____

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? _____

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

23. Signature **H. Handley** (M. D. or other) _____
Address **Springfield Mo.** Date signed **11/3/46**

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

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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.....

Ogle Stone Jr.

Licensed Embalmer No. *4176*

P. O. Address.....

Springfield

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.