

No. 2  
-8-13  
5-17-39  
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THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED FEB 5 1947  
Registration District No. 38

Primary Registration District No. 3006

State File No. \_\_\_\_\_  
Registrar's No. 36

1. PLACE OF DEATH:

(a) County Boone

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

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

(d) Length of stay: In hospital or institution 1 1/2 Hours  
(Specify whether \_\_\_\_\_)

In this community 40 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone

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

(d) Street No. 810 W. Broadway  
(If rural, give location)

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

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

3. (a) PRINT FULL NAME WILLIAM IVIS McBRIDE

3. (b) If veteran, name war None

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 29  
year 1947 hour 12 minute 45 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.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Clare Morganthaler McBride

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

7. Birth date of deceased 2 - 17 - 1906  
(Month) (Day) (Year)

Immediate cause of death Gunshot wound

Due to Self inflicted

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years 40 Months 11 Days 12  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Insurance

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

MOTHER FATHER {

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

12. Name James William McBride

13. Birthplace Boone County Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Gora Dunbar

15. Birthplace Boone County Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. W.I. McBride

(b) Address 810 W. Broadway, Columbia, Mo.

17. (a) Burial (b) Date thereof 2-1-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Parson Funeral Service  
Columbia, Mo.

(b) Address \_\_\_\_\_

19. (a) 2-1-47 (b) Mrs. R.E. Palmer  
(Date received local registrar) (Registrar's signature)

22. If death was due to external cause, fill in the following:

(a) Accident, suicide, or homicide (specify) suicide

(b) Date of occurrence Jan 29-1947

(c) Where did injury occur? Columbia Boone Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Home (Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury 3

23. Signatures Stewart Carroll  
(M.D. or other)

Address Columbia Mo Date signed 2/9/47

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

2  
4

31

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 2-4-47

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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

*Charles L. Taylor*

Licensed Embalmer No.

4132

P. O. Address

*Columbia, Mo*

**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.