

No. 2
12-45
-17-39
X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40891

FILED DEC 17 1947

State File No. _____

Registration District No. 37

Primary Registration District No. 4049

Registrar's No. 31

1. PLACE OF DEATH:

(a) County Boone

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

(c) Name of hospital or institution: /

(If not in hospital or institution, write street number or location)

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

In this community Entire life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone / 10

(c) City or town Centralia, Missouri /
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location) 0

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

If yes, name country _____

3. (a) PRINT FULL NAME James Riley McBride

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased June 27 1863
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>84</u>	<u>5</u>	<u>13</u>	_____ hr. _____ min.

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

10. Usual occupation Baggageman Wabash R.R.

11. Industry or business Railroad

12. Name David McBride

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

14. Maiden name Martha Ann Roberts

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

16. (a) Informant Mrs. Virgil Doty

(b) Address Centralia, Missouri

17. (a) Burial (b) Date thereof 12-11-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centralia, Missouri

18. (a) Signature of funeral director Balley Fun. Home

(b) Address Centralia Missouri

19. (a) 12-12-47 (b) Moore Mc Bald
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 10 - 1947
year 1947 hour 4:30 a.m. minute _____ M.

21. I hereby certify that I attended the deceased from 3 several years
Dec 10 1947 to _____ 19____;
that I last saw him alive on Dec 10 _____ 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 2 days

Due to _____

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: None
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?
(Specify type of place) _____

While at work? _____ (e) Means of injury _____ 0

23. Signature W. G. White (M. D. or other) _____

Address Centralia Mo Date signed _____

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

MOTHER FATHER

Dec 11 - 47

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 12-16-47

JAN 2 1948

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 Paul J. Baller
Licensed Embalmer No. 4206
P. O. Address Centralia, 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.

Registration District No. 37 Primary Registration District No. 4049

1. PLACE OF DEATH:
(a) County Reynolds
(b) City or town Centralia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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)

3. (a) PRINT FULL NAME James Riley McBride
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased June 2 (Month) (Day) (Year)

8. AGE: Years 44 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) MO

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Dec 12-1947 (Date received local registrar) (b) Maud McBride (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Day _____
year 1947 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

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

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

40891