No. 300
10-48

FILED SEP 24 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33639

BIRTH NO. 56363 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8276

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis Mo
c. LENGTH OF STAY (in this place): 5 hrs 45 min
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Marys Infirmary

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis
d. STREET ADDRESS (If rural, give location): 4334 St Ferdinand 2119 0

3. NAME OF DECEASED (Type or Print)
a. (First) b. (Middle) c. (Last): McBride

4. DATE OF DEATH (Month) (Day) (Year): 8-15-53

5. SEX: male 2
6. COLOR OR RACE: Negra
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 0
8. DATE OF BIRTH: 8-15-53
9. AGE (In years last birthday): IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours 5 Min. 45

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Missouri St Louis. 0
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Charles McBride
13b. MOTHER'S MAIDEN NAME: Cleo Hunt
14. NAME OF HUSBAND OR WIFE: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT'S SIGNATURE OR NAME: Cleo McBride. ADDRESS: above

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) prematurity 20 weeks gestation.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 776X

22. *I hereby certify that I attended the deceased from* 1:00 am 8-15, 1953, *to* 6:45 am 8-15, 1953, *that I last saw the deceased alive on* 8-15-53, 19__, *and that death occurred at* 6:45 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wm Smiley M.D.
23b. ADDRESS: 4105 a Easton
23c. DATE SIGNED: 8-15-53

24a. BURIAL, CREMATION, REMOVAL (Specify)
24b. DATE: AUG 31 1953
24c. NAME OF CEMETERY OR CREMATORY: Anatomical Board
24d. LOCATION (City, town, or county) (State): St. Louis, Mo.

DATE REC'D BY LOCAL: AUG 26 1953
REGISTRAR'S SIGNATURE: J. Earl Smith M.D.
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Rowland Mortuary Service 4104 Manchester Ave.

S.P. (Licensed Embalmer's Statement on Reverse Side)

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.....

....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.