

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3673

State File No.

FILED JAN 29 1954

BIRTH NO. _____		REG. DIST. NO. <u>3353-28</u>		PRIMARY REG. DIST. NO. <u>4492</u>		Registrar's No. <u>48</u>		
1. PLACE OF DEATH a. COUNTY <u>SCOTT</u> <u>1000</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>SCOTT</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ORAN</u>		c. LENGTH OF STAY (in this place) <u>13 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ORAN</u> <u>1000</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ORAN</u>				d. STREET ADDRESS (If rural, give location) <u>ORAN</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>ROBERT</u>			b. (Middle) <u>EUGENE</u>			c. (Last) <u>MCBRIDE</u>		
4. DATE OF DEATH (Month) (Day) (Year) <u>JAN. 17 1954</u>								
5. SEX <u>MALE</u> <u>0</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>MAY 23 1884</u>	9. AGE (In years last birthday) <u>69</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHOE WORKER RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SHOE FACTORY</u>		11. BIRTHPLACE (State or foreign country) <u>UNIONTOWN KENTUCKY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13a. FATHER'S NAME <u>LLOYD MCBRIDE</u>			13b. MOTHER'S MAIDEN NAME <u>MAGGIE DRURY</u>			14. NAME OF HUSBAND OR WIFE <u>FRANCE SOPHIA MCBRIDE</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>487-24-3654</u>		17. INFORMANT'S SIGNATURE OR NAME <u>FRANCES SOPHIA MCBRIDE</u>		ADDRESS <u>ORAN, MO.</u>		
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>					INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES DUE TO (b) <u>none</u>						
		DUE TO (c) <u>none</u>						
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>						
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>none</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>none</u>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>none</u>				
22. I hereby certify that I attended the deceased from <u>10 AM 1-15, 1954</u> , to <u>5 AM 1-17, 1954</u> , that I last saw the deceased alive on <u>1-17, 1954</u> , and that death occurred at <u>5:00 A. M.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Lucy W. Lake, D.O.</u>				23b. ADDRESS <u>Oran, Mo.</u>		23c. DATE SIGNED <u>1-23-54</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>JAN. 20 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>NEW GUARDIAN ANGELS</u>		24d. LOCATION (City, town, or county) (State) <u>ORAN SCOTT MO.</u>		
DATE REC'D BY LOCAL REG. <u>1-25-54</u>		REGISTRAR'S SIGNATURE <u>Miss Paul Bradley Hoff</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Earl Smith</u>		ADDRESS <u>ORAN, MO.</u>		

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

RECEIVED 1-26-54
SCOTT COUNTY HEALTH CENTER

CO. FILE NO. 154-21

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 Earl Smith

Licensed Embalmer No. 2676

P. O. Address Orian, 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.