

FILED NOV 14 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **32199**BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **38** PRIMARY REG. DIST. NO. **3006** Registrar's No. **295**

1. PLACE OF DEATH a. COUNTY <b>Boone</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Boone</b>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Columbia</b>		c. LENGTH OF STAY (in this place) <b>4 Mos.</b>	c. CITY OR TOWN <b>Columbia</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>230 Sexton Road</b>			STREET ADDRESS (If rural, give location) <b>622 Washington</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>Mattie</b> b. (Middle) <b>Dunbar</b> c. (Last) <b>McBride</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 5, 1955</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Feb. 9, 1865</b>		9. AGE (In years last birthday) <b>90</b>
IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>John W. Dunbar</b>		13b. MOTHER'S MAIDEN NAME <b>Talitha Angell</b>		14. NAME OF HUSBAND <b>David Lee McBride</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>- - - -</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs Silas Roberts, Columbia, Mo.</b>	ADDRESS <b>Dec 4 50</b>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>* This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic Myocarditis</b> ANTECEDENT CAUSES <b>Senility</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <b>4222H</b> Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>17</b>
19a. DATE OF OPERATION <b>1946</b>	19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma of Cecum</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY. (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>46 Nov 5 55</b> , to <b>Nov 5 55</b> , that I last saw the deceased alive on <b>Nov 7 55</b> , and that death occurred at <b>8 P. M.</b> , from the causes and on the date stated above.					
23a. SIGNATURE <b>Paul D. Dietrich MD</b>		23b. ADDRESS <b>Prof Bly Roberts</b>		23c. DATE SIGNED <b>Nov. 7 1955</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>11/7/1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Red Top</b>	24d. LOCATION (City, town, or county) (State) <b>Hallsville, Mo. R.F.D.</b>		
DATE REC'D BY LOCAL REG. <b>Nov 7 1955</b>	REGISTRAR'S SIGNATURE <b>Mrs. R. E. Palmer</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>31 Memorial Funeral Home</b>	ADDRESS <b>Columbia, Mo.</b>		

(Licensed Embalmer's Statement on Reverse Side)

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

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, ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Lyman H. Sprinkle*

Licensed Embalmer No. *401*

P. O. Address *Columbus*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.