

FILED MAR 12 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3805

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 93

1. PLACE OF DEATH a. COUNTY <u>BOONE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). ---a. STATE <u>MISSOURI</u> --- b. COUNTY <u>LACLEDE</u>	
b. CITY OR TOWN <u>COLUMBIA, MISSOURI</u>	c. LENGTH OF STAY (in this place) <u>3 1/2 days</u>	c. CITY OR TOWN <u>COMPELTON</u>	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 <u>UNIVERSITY HOSPITAL</u>		e. STREET ADDRESS (If rural, give location) <u>0539</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>BERTHA</u>	b. (Middle)	c. (Last) <u>McBRIDE</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 7 1956</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Jan. 11 1918</u>	9. AGE (In years last birthday) <u>38</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (This kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <u>Laclede Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Bill Mayfield</u>	13b. MOTHER'S MAIDEN NAME <u>Bertha Mayfield</u>	14. NAME OF HUSBAND OR WIFE <u>John McBride</u>
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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. _____	17. INFORMANT'S SIGNATURE OR NAME <u>John McBride</u>	ADDRESS _____
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Polynuronitis, idiopathic</u>		
	ANTECEDENT CAUSES 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 Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <u>364x</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from March 3, 1956, to March 7, 1956, that I last saw the deceased alive on March 6, 1956, and that death occurred at 12:50 A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>John H. Killough, M.D.</u> (Degree or title)	23b. ADDRESS <u>University Hospital</u>	23c. DATE SIGNED <u>March 7</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>3-7-56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Porter Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Laclede Co. Mo.</u>
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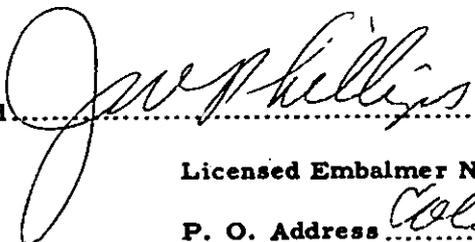
DATE REC'D BY LOCAL REG. <u>Mar. 7 1956</u>	REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Parber Funeral Service</u>	ADDRESS <u>Columbia</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

Student.....
Signature of Student Embalmer

Signed .....
Licensed Embalmer No. 482.....
P. O. Address .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.