

FILED MAR 19 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8143**
Registrar's No. **267**

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) 60 yrs		e. STREET ADDRESS (If rural, give location) Rt #8	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) o. Methodist Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) Ella	b. (Middle) Lee	c. (Last) McBride	4. DATE OF DEATH (Month) (Day) (Year)
				Mar 6 1956

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Oct. 3, 1894	9. AGE (In years) (Month) (Day) (Year) 61	# UNDER 1 YEAR Months	# UNDER 24 HRS. Hour	# UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and State or Foreign Country) St. Joseph Mo	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME William Cook	13b. MOTHER'S MAIDEN NAME Lena Hues	14. NAME OF HUSBAND OR WIFE Paul J. McBride
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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) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Paul J. McBride	ADDRESS St. Joseph, Mo
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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, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		10 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis & Hypertension DUE TO (c) Diabetes Mellitus		10 yrs 8 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertension Secum			10 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 **Oct-16, 1948**, to **Mar-6, 1956**, that I last saw the deceased alive on **March, 1956**, and that death occurred at **4:30** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) T. L. Howden M.D.	23b. ADDRESS (City) 419 Kirkpatrick Bldg. St. Joseph	23c. DATE SIGNED 3-7-56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3/8/56	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) (State) St. Joseph Mo
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DATE REC'D BY LOCAL REG Mar 12, 1956	REGISTRAR'S SIGNATURE Lochner M. Allison	25. FUNERAL DIRECTOR'S SIGNATURE (Address) St. Joseph
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(Licensed Embalmer Statement on Reverse Side)

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

MAR 20 1956

MAR 5 1956

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

Student.....
Signature of Student Embalmer

Signed *Alvin C. Pagan*

Licensed Embalmer No. *479*

P. O. Address *St. Joseph*

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.