Health, Welfare, Public Service

300
1-56

FILED SEP 27 1956

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

32656

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2047

1. PLACE OF DEATH a. COUNTY St. Louis	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmomd Heights — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN Wellston 4301 — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Marys Hosp. — Length of stay in 1b 10 days	d. STREET ADDRESS (If outside, give location) 1810 Kienlen — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Charles	E.	McBee		8	29	56

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
Male	White		June 2, 1899	57		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY?
Labour	City of Wellston	Raymondville Mo.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Arthur McBee	Minnie Gartin

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	Address
No	None	499-12-4843	Mrs Irva McBee	1810 Kienlen

MEDICAL CERTIFICATION

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

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of lung.

INTERVAL BETWEEN ONSET AND DEATH: 9 MO

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ✓ DUE TO (c) ✓

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 163X

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year ✓

20d. INJURY OCCURRED WHILE AT WORK ☐ ✓ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) ✓

20f. CITY, TOWN, OR LOCATION ✓ COUNTY STATE

21. I attended the deceased from 12/1965, to 8/29/56 and last saw ~~her~~ him alive on 8/29/56

Death occurred at 1140 A.m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
Bruce J O'Reilly MD	730 Hodiamont	8/30/56

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county)	(State)
Burial	8-31-56	Laurel Hill Cemetery	St. Louis	Missouri

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Jos.W.ClarkF.H.Inc.	1125 Hodiamont	8/30/56	Wechect R. Domkerg Jm

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student..... Signed Alfred F Boedek

Signature of Student Embalmer

Licensed Embalmer No. 26

P. O. Address 1125 Hodge

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (I 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.