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FILED OCT 16 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35846

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8648

1. PLACE OF DEATH
a. COUNTY: None
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place): abt. 10 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. Homer G. Phillips 2210

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: None Mo
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 912 N. Garrison

3. NAME OF DECEASED (Type or Print)
a. (First): Green
b. (Middle):
c. (Last): McBride

4. DATE OF DEATH (Month) 9 (Day) 15 (Year) 56

5. SEX: M
6. COLOR OR RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: Unknown
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABOER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and State or Foreign Country): Mississippi
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Unknown

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'S SIGNATURE OR NAME: Henry McBride — ADDRESS: 3149 A Sherdian

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arterio Scleratic Heart

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Disease; Generalized
DUE TO (c): Arterio Sclerosis

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: 420.0

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 2201 m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Joseph M. Quinn, Dept. Coroner
23b. ADDRESS: 1300 Clark
23c. DATE SIGNED: 9/19/56

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 9-20-56
24c. NAME OF CEMETERY OR CREMATORY: OAK Dale Cemetery
24d. LOCATION (City, town, or county): Lemay (State): Mo.

DATE REC'D BY LOCAL REG.: SEP 19 1956
REGISTRAR'S SIGNATURE: Karl Smith, MD
25. FUNERAL DIRECTOR'S SIGNATURE: Thomas Jackson — ADDRESS: 2726 Dickson St.

(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, or by .....

..... Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed John K Cunningham

Licensed Embalmer No. 4476

P. O. Address 240 [illegible]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.