

health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007391
STATE FILE NUMBER
2-1495
Registrar's No.

FILED FEB 26 1959

Registration District No. _____ Primary Registration District No. _____

300
-57

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>St. Louis</u> TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2110 Delmar Blvd.</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>2110 Delmar Blvd.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Washington</u> Middle <u>McBryde</u> Last			4. DATE OF DEATH Month <u>2</u> - Day <u>8</u> - Year <u>1959</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9 - 21 - 97</u>	9. AGE (In years last birthday) <u>61</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Emerson Elec. Co.</u>	11. BIRTHPLACE (City and state or country) <u>Bessmar, Alabama</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Will McBryde</u>	13b. MOTHER'S MAIDEN NAME <u>Angelle</u>	14. NAME OF HUSBAND OR WIFE <u>Clara McBryde</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. <u>493-01-4924</u>	17. INFORMANT <u>Clara McBryde</u> Address <u>2110 Delmar Blvd.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>H.C.V.D. & MYOCARDITIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>H.C.V.D. + RT. HEMIPLEGIA</u>	<u>1 yr.</u>
	DUE TO (c) <u>C.V.A. + Hypertension</u>	<u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>443X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>443X</u>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
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21. I attended the deceased from Dec. 28, 1958 to 2-6-59 and last saw her ^{him} alive on 2-6-59
Death occurred at 14 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

21a. SIGNATURE <u>James M. D. Smith, M.D.</u> (Degree or title)	22b. ADDRESS <u>916 A. N. TAYLOR</u>	22c. DATE SIGNED <u>2-7-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/14/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Father Dickson Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County</u> <u>MO.</u>
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24. FUNERAL DIRECTOR <u>McClain-Bannister</u> ADDRESS <u>4251 Washington</u>	25. DATE RECD. BY LOCAL REG. <u>FEB 11 1959</u>	26. REGISTRAR'S SIGNATURE <u>Roan Smith, M.D.</u>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Leroy W. Panister*

Licensed Embalmer No. *4523*
P. O. Address *4251 Washing*

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.