Health, Welfare Public Service

300 -57

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FILED APR 14 1959

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-008609

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 99

1. PLACE OF DEATH
a. COUNTY Callaway
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Fulton — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Hospital #1 — Length of stay in 1b 2 yrs 4 Mo.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Cole
c. CITY OR TOWN Jefferson City 0264 — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 424 Mo. Hotel — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First DAISY Middle Last McBRIDE

4. DATE OF DEATH Month April Day 4 Year 1959

5. SEX female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐
8. DATE OF BIRTH 7-19-1874
9. AGE (In years last birthday) 84 — 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) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (City and state or country) Pleasant Hill Mo.
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Thomas Dewar
13b. MOTHER'S MAIDEN NAME Martha Woodruff
14. NAME OF HUSBAND OR WIFE M. A. McBride

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 St. Hospital #1 Address Fulton Mo.

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) Cerebro-Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) 331X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Brain Syndrome with Cerebral Arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐ 0

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 12-13-1956, to 4-4-1959 and last saw her alive on 4-4-1959
Death occurred at 7:20 a. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) H. J. Freund M.D.
22b. ADDRESS State Hospital #1
22c. DATE SIGNED 4-4-1959

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 4/7/1959
23c. NAME OF CEMETERY OR CREMATORY Warrensburg.
23d. LOCATION (City, town, or county) (State) Warrensburg, Missouri

24. FUNERAL DIRECTOR ADDRESS Thorpe J. Gordon, Jefferson City, Mo
25. DATE RECD. BY LOCAL REG. April-5-1959
26. REGISTRAR'S SIGNATURE Maretta Lawrence

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 ..... Signed .....
Signature of Student Embalmer

Licensed Embalmer No. 1786

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.