

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026334

FILED VS JUL 21 1959

STATE FILE NUMBER

Registration District No. 516 Primary Registration District No. _____ Registrar's No. 264

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Francois</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Francois Township</u>		Length of stay in 1b <u>20 das.</u>		c. CITY OR TOWN <u>Desloge</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>Mo. State Hospital #4</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Unknown</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>MELVIN</u> Last <u>McNABB</u>				4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1959</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>Feb. 25, 1888</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>11</u>	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tinner and well drilling</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Belgrade, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Frank McNabb</u>			13b. MOTHER'S MAIDEN NAME <u>Addie King</u>			14. NAME OF HUSBAND OR WIFE <u>Gladys Ritter</u>			
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>495-36-7943</u>		17. INFORMANT Address <u>Records, State Hospital No. 4, Farmington, Mo.</u>				
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>Bronchial pneumonia - - - - -</u>							INTERVAL BETWEEN ONSET AND DEATH <u>abt. 2 das.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Arteriosclerotic Heart Disease with auricular fibrillation and congestive heart failure - -</u>					Unknown.		
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Psychosis with cerebral arteriosclerosis.</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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.)					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		Month, Day, Year _____							
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	
21. I attended the deceased from <u>June 16, 1959</u> to <u>July 6, 1959</u> and last saw ^{BOX} him alive on <u>July 6, 1959</u> Death occurred at <u>6:40 A. M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>John A. Brennan M.D.</u>				22b. ADDRESS <u>State Hospital No. 4 Farmington, Missouri</u>				22c. DATE SIGNED <u>7-8-59</u>	
23a. BURIAL (CREMATION, REMOVAL) (Specify) <u>Burial</u>		23b. DATE <u>July 8, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parkview Cemetery</u>		23d. LOCATION (City, town, or county) <u>Highway 67- St. Francois Co., Mo.</u>				
24. FUNERAL DIRECTOR <u>Albin Hood Flat River Mo</u>			ADDRESS <u>July 11, 1959</u>		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE <u>Ethel Rudloff</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Abrie Hood

Licensed Embalmer No. 2780
P. O. Address Flat River, Mo.

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.