

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-037826

SL 8316

XC 158429 FILED VS OCT 23 1959

UNRECORDED

Registration District No. _____

Primary Registration District No. _____

Registrar's No. **9420**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N GRAND, ST LOUIS, MO Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET ADM HOSPITAL Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY ST CLAIR c. CITY OR TOWN DUPO Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) ROUTE 1 MCBRIDE AVENUE Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last OWEN E. MCBRIDE			4. DATE OF DEATH Month Day Year OCTOBER 13, 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-24-94	9. AGE (last birthday) 64 IF UNDER 1 YEAR: Months 11 Days 2 Hours _____ Min. _____ IF UNDER 24 HR: _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUS DRIVER		10b. KIND OF BUSINESS OR INDUSTRY FALLING SPRINGS, MO.	11. BIRTHPLACE (City and state or country) FALLING SPRINGS, MO.	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME MICHAEL MCBRIDE		13b. MOTHER'S MAIDEN NAME SADIE LOUIS	14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. 318-24-1658	17. INFORMANT Address VA HOSP. RECORDS, ST. LOUIS, MO.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC COMA DUE TO (b) LAENNEC'S CERRHOSIS DUE TO (c) - 581.1 - Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) GASTRIC DILATION			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 checked="" type="checkbox"/> NO <input 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. Attended the deceased from 8-18-59 to 10-13-59 and last saw him alive on 10-13-59 Death occurred at 8:35 a. m on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Degree or title) MARY MARTIN PETERSON, M.D.		22b. ADDRESS VAH, ST. LOUIS, MO.		22c. DATE SIGNED 10/14/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE OCT. 14, 1959	23c. NAME OF CEMETERY OR CREMATORY ST JOSEPH'S	23d. LOCATION (City, town, or county) (State) ST CLAIR COUNTY, ILLINOIS	
24. FUNERAL DIRECTOR ADDRESS HAROLD A. DASHNER DUPO, Illinois		25. DATE RECD. BY LOCAL REG. OCT 14 59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	

(Licensed Embalmer's Statement on Reverse Side)

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Harold P. Parker*

Licensed Embalmer No. 4621

P. O. Address *Days Illinois*

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.