

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-008553

FILED VS MAR 7 1960

2 1698

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> Length of stay in 1b <u>2Mo 8Days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>City Hospital DOA</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u> c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1811 So. 3rd. St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Wendell</u> Middle <u>Irvin</u> Last <u>McBride</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>13</u> Year <u>1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Born <input type="checkbox"/>	8. DATE OF BIRTH <u>12/5/59</u>	9. AGE (last birthday) <u>2mo 8days</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>8</u> IF UNDER 24 HR Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baby</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>x</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>			
10c. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Wendell Irvin McBride</u>		13b. MOTHER'S MAIDEN NAME <u>Bethel Mitchell</u>			
13c. NAME OF HUSBAND OR WIFE <u>XXX</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>x</u>		16. SOCIAL SECURITY NO. <u>XXX</u>			
17. INFORMANT <u>W.I. McBride</u>		17. ADDRESS <u>1811 So. 3rd St. City</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>Bilateral Broncho Pneumonia</u> DUE TO (b) <u>491x</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				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 type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>		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 _____ to _____ and last saw her/him alive on _____. Death occurred at <u>1130 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Paul Simon Deputy Coroner</u>			22b. ADDRESS <u>1300 Clark</u>		22c. DATE SIGNED <u>2/15/60</u>		
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>2/15/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ava Evergreen</u>		23d. LOCATION (City, town, or county) (State) <u>Ava Illinois</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Wilson Funeral Home Ava Ill.</u>			25. DATE RECD. BY LOCAL REG. <u>FEB 15 1960</u>		26. REGISTRAR'S SIGNATURE <u>Paul Smith M.D.</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

Frank Trokoff

Licensed Embalmer No. 435

P. O. Address St. Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.