RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS MAR 2 8 1960

60-009984

STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 342

IDED

1. PLACE OF DEATH
a. COUNTY Buchanan
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph — Length of stay in 1b Lifetime
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1804 Faraon St. Goforth Nursing Home — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Buchanan
c. CITY OR TOWN St.Joseph — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) R#3 — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Lalla Middle Brunner Last McBride

4. DATE OF DEATH Month March Day 16, Year 1960

5. SEX Female
6. COLOR OR RACE White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH Jan.31,1883
9. AGE (last birthday) 77 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife& Ret. Shirt inspector.
10b. KIND OF BUSINESS OR INDUSTRY Sun Mfg. Co.
11. BIRTHPLACE (City and state or country) St. Joseph, Missouri.
12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME A. Brunner
13b. MOTHER'S MAIDEN NAME Katherine Snyder
14. NAME OF HUSBAND OR WIFE Fred McBride

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 491-10-1355
17. INFORMANT D. S. Baine Address St.Joseph, 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) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH Unk.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
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 3/14/60, to 3/16/60 and last saw her alive on 3/15/60
Death occurred at 4:40 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) S.E. Meluney M.D.
22b. ADDRESS Social Welfare Board 10th & Olive, St. Joseph, Mo.
22c. DATE SIGNED 3/17/60

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Mar.19,1960
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery
23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri.

24. FUNERAL DIRECTOR Meurhoff & Fleeman by [illegible] ADDRESS St.Joseph, Mo.
25. DATE RECD. BY LOCAL REG. Mar. 23 1960
26. REGISTRAR'S SIGNATURE Mrs Clark Goodell

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF 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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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