

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-008946

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1298

FILED MAR 29 1961

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
Length of stay in 1b 45 YEARS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 700 CHESTNUT		d. STREET ADDRESS (If outside, give location) 700 CHESTNUT	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last JAMES ELWIN McBRIDE			4. DATE OF DEATH Month Day Year MARCH 11 1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH DEC 28 1876	9. AGE (last birthday) 84	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) ACCOUNTANT		10b. KIND OF BUSINESS OR INDUSTRY MO. PACIFIC R.R.		11. BIRTHPLACE (City and state or country) GREEN Co. Indiana		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Charles A. McBride		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Margaret McBride		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Margaret McBride 700 Chestnut		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Wrenia

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Renal arterio sclerosis 5 yrs

DUE TO (c) Cerebral and General arterio-sclerosis 10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Inter trochanteric Fracture Left Hip

PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

INTERVAL BETWEEN ONSET AND DEATH 21 days

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.) Fall at Home.
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. Feb 8-61		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) in Home	20f. CITY, TOWN, OR LOCATION COUNTY STATE Kansas City Jackson, Mo.
21. I attended the deceased from Feb 8-61 to March 11-61 and last saw her/him alive on March 10-1961		
Death occurred at 3:20 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) Leo A. O'Brien M.D.		22b. ADDRESS 306 E 12 K.C. 6 Mo		22c. DATE SIGNED 3-12-61
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Mar 13, 1961	23c. NAME OF CEMETERY OR CREMATORY Mt Moriah	23d. LOCATION (City, town, or county) (State) Kansas City, Mo.	
24. FUNERAL DIRECTOR ADDRESS Muehlebach 6800 Troost		25. DATE RECD. BY LOCAL REG. 3-13-61	26. REGISTRAR'S SIGNATURE Ruth Long	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

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 J. T. Crowell

Licensed Embalmer No. 4904

P. O. Address N. C. 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.