

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

20130

**1. PLACE OF DEATH**

County New Madrid Registration District No. 345  
Township Big Frame Primary Registration District No. 5800  
City..... (No. ....) St. .... Ward)

**2. FULL NAME**

Geneva M<sup>c</sup> Cormick  
(a) Residence. No. .... St. .... Ward. ....  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>child</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>July 15 - 1930</u>		
7. AGE	YEARS	MONTHS
	<u>4</u>	<u>8</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>child</u> (b) General nature of industry, business, or establishment in which employed (or employer). (c) Name of employer		

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 23 1930  
17. I HEREBY CERTIFY, That I attended deceased from June 23, 1930, to June 24, 1930, that I last saw him alive on June 23, 1930, and that death occurred, on the date stated above, at 11:30 AM.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Colitis  
119B/1303 (duration) yrs. mos. ds.  
CONTRIBUTORY (SECONDARY)  
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH.....  
DID AN OPERATION PRECEDE DEATH? DATE OF.....  
WAS THERE AN AUTOPSY?.....  
WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) J. H. Palmer, M. D.  
6/23, 1930 (Address) Sikeston Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

9. BIRTHPLACE (CITY OR TOWN) Monroe  
(STATE OR COUNTRY) Mo

PARENTS

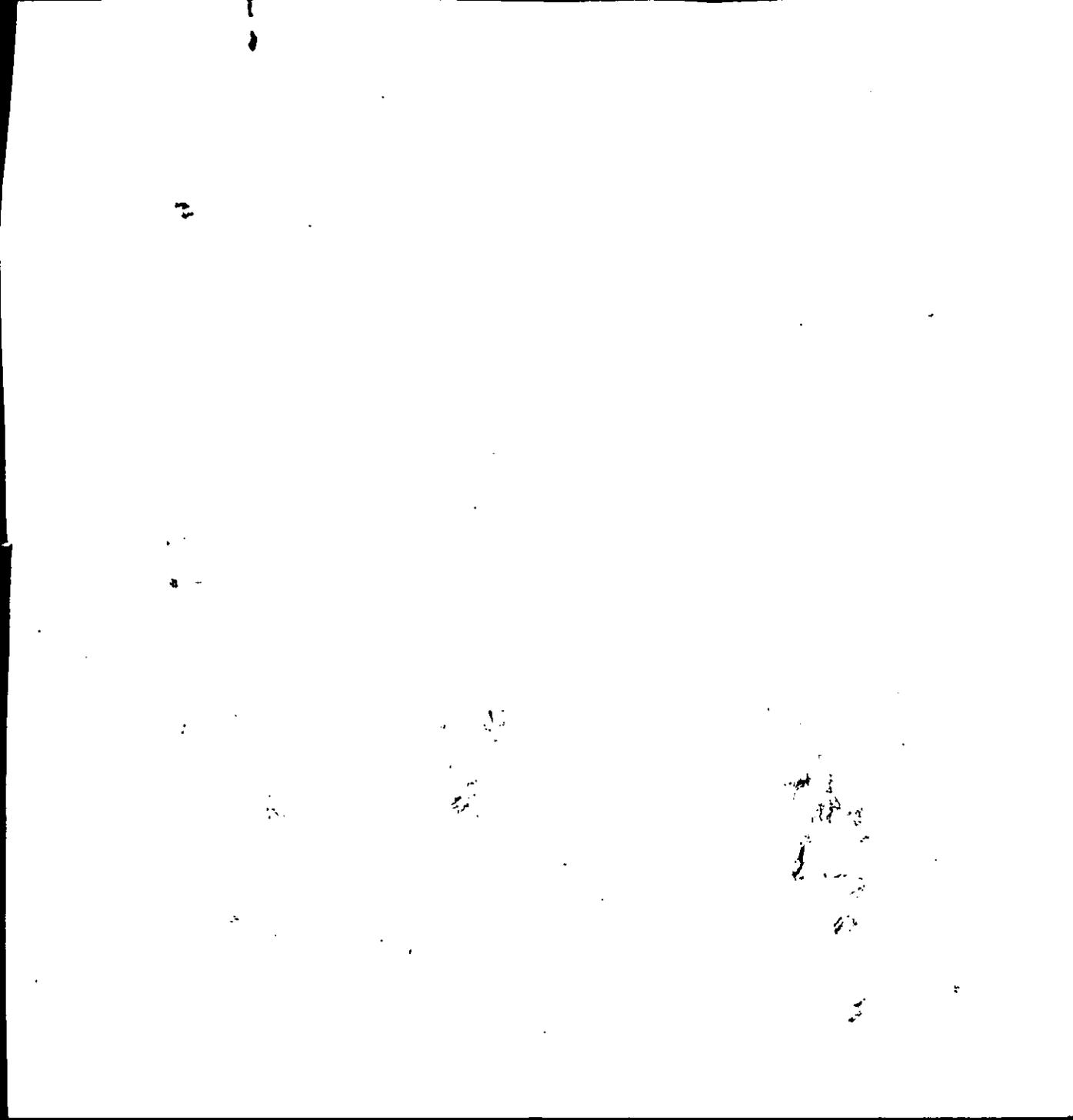
10. NAME OF FATHER Isaac M<sup>c</sup> Cormick  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Oran  
(STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Helen Statham  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) New Madrid  
(STATE OR COUNTRY) Mo

14. INFORMANT Isaac M<sup>c</sup> Cormick  
(Address) Monroe

15. FILED....., 19..... REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Cape Girardeau  
DATE OF BURIAL 6/24 1930  
20. UNDERTAKER H. J. Welch Sikeston Mo  
ADDRESS



**MISSOURI STATE BOARD OF HEALTH**  
**BUREAU OF VITAL STATISTICS**  
**CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
 FOR MUST BE WRITTEN ON  
 THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County New Madrid Registration District No. 345 File No. ....  
 Township Big Prairie Primary Registration District No. 3800 Registered No. ....  
 City ..... (No. ....) St. .... Ward)

**2. FULL NAME** Geneva McCormick

(a) Residence. No. .... St. .... Ward. ....  
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work ..... (duration) yrs. mos. da.  
 (b) General nature of industry, business, or establishment in which employed (or employer) ..... (duration) yrs. mos. da.  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY)

14. INFORMANT (Address)

FILED 9/10 30 D. A. Chiles REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 23 1920

17. I HEREBY CERTIFY That I attended deceased from ..... 19....., 19..... that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at .....

THE CAUSE OF DEATH WAS AS FOLLOWS:

..... (duration) yrs. mos. da.  
 CONTRIBUTORY (SECONDARY) ..... (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ..... M. D. , 19 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AND RETURNED BY MAIL

SUPPLEMENTARY

