

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

Do not use this space.

26674

1. PLACE OF DEATH

County Jackson
Township Jaw
City Jackson City (No. Research Hospital)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 3278 (Ward)

2. FULL NAME

Andrew Boring McCormick
(a) Residence. No. 2933 Holmes St. 3 Ward.

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. ~~MARRIED, WIDOWED, OR DIVORCED~~ HUSBAND OF (or) WIFE OF Mrs Belle M. McCormick

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 17-18'57

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>72</u>	<u>7</u>	<u>19</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Engineer St Ry.
(b) General nature of industry, business, or establishment in which employed (or employer) 15th Grand
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) New Lisbon Ohio
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Thos. Benton M. McCormick

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

12. MAIDEN NAME OF MOTHER Martha Chain

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

14. INFORMANT Mrs Belle M. McCormick
(Address) 2933 Holmes.

15. FILED 8/8 1930 M. M. Crowe
assk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3 Wednesday
16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 6 1930

17. I HEREBY CERTIFY, That I attended deceased from June 28 to August 6, 1930 that I last saw him alive on August 6, 1930, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Embolism
18. CONTRIBUTOR (SECONDARY) Prostatic Hypertrophy
Uremia (duration) _____ yrs. _____ mos. _____ ds.

19. WHERE WAS DISEASE CONTRACTED Not known

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? None (duration) _____ yrs. _____ mos. _____ ds.

20. WHAT TEST CONFIRMED DIAGNOSIS Clinical

(Signed) W. H. McCaskey M. D.
1930 (Address) Ke. 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Parallton Mo. DATE OF BURIAL Aug 9 1930

20. UNDERTAKER Eyles Funeral Home ADDRESS 1800 Linwood

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

