

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

Do not use this space.

1. PLACE OF DEATH

21 County Chicout Registration District No. 173 File No. 72/2355
 Township Wayland Primary Registration District No. 5-240 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Estes Lee McCormack

(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 M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S.
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Schulby
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 29 - 1920
 7. AGE: YEARS 12 MONTHS 0 DAYS 1 If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Schulby
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

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

10. NAME OF FATHER Wm F. McCormack
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Montgomery City - Mo
 12. MAIDEN NAME OF MOTHER Minnie Wright
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo Co.

14. INFORMANT Mrs. Minnie Perry
 (Address) Phone will info.

15. FILED July 1, 1932 J. D. McAdams
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7 - 1 1932

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Phos. in chest by insect
VIOL
 _____ (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Run over by truck
with gravel (duration) _____ yrs. _____ mos. _____ ds.

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

2 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Mossburn Coover, M. D.
7/1 1932 (Address) Falishby 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 Mosshfield DATE OF BURIAL July 9 1932

20. UNDERTAKER H A Perry & Son ADDRESS Callow

N. B. 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.

AUG 23 1932

...ly supplied. A GE should be stated. ACTUALLY. PHYSICIAN
...ified. Exact state of ...
... STATE ...

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Chariton Registration District No. 173
 Township Wayland Primary Registration District No. 5240
 City (No. _____) St. _____ Ward _____

2. FULL NAME Lester Lee McCornack
 (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 m 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. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19____

19. UNDERTAKER (ADDRESS) _____

20. FILED July 1 1932 J.D. McAdams Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 1 1932

22. I HEREBY CERTIFY That I attended deceased from _____ to _____, 19____

I last saw him alive on _____, 19____. Death is said to have occurred on the _____ stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Ray over chest by truck
Chest was crushed against
physical signs discoloration
when chest partly compressed
Other contributory causes of importance
labor breathing
Ray over by truck
loaded with gravel
In Village Prairie Hill Mo
 Name of operation Driver did not know it
 What test confirmed diagnosis? written on return Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury 7-1-1932
 Where and injury occurred? Prairie Hill Mo
 (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.
In public road on street

Manner of injury Ray against edge of board
 Nature of injury Major laceration of chest

24. Was disease or injury in any way related to occupation of deceased?
Yes If so, specify Ray over upper left chest

(Signed) J.D. McAdams M. D.
 (Address) Prairie Hill Mo

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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