NOV 9 1934

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

Do not use this space.

37160

1. PLACE OF DEATH

County St. Francois — Registration District No. 773

Township St. Francois — Primary Registration District No. 6018A

~~Near~~ City ~~Farmington, Mo.~~ (No. ..... , ... St. ..... Ward)

File No. .....

Registered No. 137

2. FULL NAME Cordes McCord

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

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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*)
Male	White	Single

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

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

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
About 63	?	?	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer

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) Indiana

FATHER

13. NAME Unknown

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

MOTHER

15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) Hospital Records Farmington, Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE State Hosp. No 4 DATE 10/22 1934

19. UNDERTAKER (ADDRESS) Cozean Farmington Mo

20. FILED Oct 21 1934 B. J. Robinson Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 20 1934

22. I HEREBY CERTIFY, That I attended deceased from Jan 1927, to Oct 20 1934

I last saw h. alive on Oct 19 1934 Death is said to have occurred on the date stated above, at 3 a.m.

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

Cerebral Apoplexy

Other contributory causes of importance

Generalized Arterio-Sclerosis

Terminal Broncho-Pneumonia

Name of operation ..... Date of .....

What test confirmed diagnosis? Clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) P. S. Tate, M. D.

(Address) Hosp. #4 Farmington Mo

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

100M-11-24-33