

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.

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

Do not use this space.

OCT 22 1935

29478

1. PLACE OF DEATH

County Jackson Registration District No. \_\_\_\_\_  
Township J. K. 2 Primary Registration District No. \_\_\_\_\_  
City A. C. No. (No. 4534-E-61st.) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 3453

2. FULL NAME

James Granville McCormick  
(a) Residence, No. 4534 E 61st. 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-26-1869  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
76 5 9

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. machinery  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. merchant  
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) Carlisle Kentucky

13. NAME James W. McCormick

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

15. MAIDEN NAME Emaline Patton

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

17. INFORMANT Granville McCormick  
(ADDRESS) Sedalia, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Sedalia, Mo. DATE Sept 7-35

19. UNDERTAKER Mrs. E. L. Foster  
(ADDRESS) 718 Broadway, W.

20. FILED 9/6 1935 M. M. Corwin  
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-5-1935  
22. I HEREBY CERTIFY, That I attended deceased from Sept 7, 1935, to Sept 4, 1935.  
I last saw him alive on Sept 4, 1935. Death is said to have occurred on the date stated above, at 8:50 am.  
The principal cause of death and related causes of importance were as follows:

Cerebral Embolus  
of 2 hrs.  
Other contributory causes of importance:  
Atherosclerosis

Date of onset 9/1/35

Name of operation none Date of \_\_\_\_\_  
What test confirmed diagnosis? none 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? no  
If so, specify \_\_\_\_\_

(Signed) J. E. Ball, M. D.  
(Address) 1102 E 47

47th Frost  
Logan 3/02

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