AUG - 5 1937

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

Do not use this space.

25963

1. PLACE OF DEATH
County St. Louis Children's Hosp. Registration District No. 1003 File No. 7137
Township ..... Primary Registration District No. ..... Registered No. 791
City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME LEONARD MC CORMICK
(a) Residence, No. FESTUS, MO. St., R.R. Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. 7 mos. 2 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): CHILD
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: CHILD
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): DEC 14-1936
7. AGE: YEARS ..... MONTHS 7 DAYS 8 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: CHILD
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): FESTUS, MO.

FATHER
13. NAME: JAMES MC CORMICK
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): SIKESTON, MO

MOTHER
15. MAIDEN NAME: NOVA CRUSE
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): FREDERICKSTOWN, MO.

17. INFORMANT (ADDRESS): F. DAVIS 500 So. Kingshighway
18. BURIAL, CREMATION, OR REMOVAL PLACE FESTUS, MO DATE JULY 28 1937
19. UNDERTAKER (ADDRESS): Albert H. Hoppe 427 N. Euclid Ave
20. FILED AUG 2 1937 J. F. Bredeck Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) JULY 26, 1937
22. I HEREBY CERTIFY, That I attended deceased from 7-20, 1937 to 7-26, 1937
I last saw him alive on 7-26, 1937. Death is said to have occurred on the date stated above, at 1050 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Bacillary Dysentery - Hiss Russell	7-14
Miliary tbc pulmonary	3 weeks before
Tuberculous Meningitis	7-21

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? Yes

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) Ezra L. Davis, Jr., M. D.
(Address) 500 S. Kingshighway

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

1. PLACE OF DEATH

County ..... Registration District No. .....

Primary Registration District No. .....

City or town ..... No. .....

2. FULL NAME .....

(a) Residence. No. ..... Street ..... Ward.

(b) Residence in city or town where death occurred ..... How long in U. S., if of foreign birth? .....

(If resident of institution give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)	6. DATE OF BIRTH (MONTH, DAY, AND YEAR)	7. AGE
				Years
				Months
				Days
				If less than 1 day, hours or minutes

8. OCCUPATION

(a) Trade, profession, or particular kind of work done, as spinner, weaver, etc.

(b) Industry or business in which work was done, as cotton mill, farm, etc.

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

10. MOTHER'S MAIDEN NAME

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

12. FATHER'S NAME

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

14. INFORMANT (ADDRESS)

15. BURIAL, CREMATION, OR REMOVAL

PLACE ..... DATE .....

16. UNDERTAKER (ADDRESS)

17. D. M. D.

18. FILED ..... 19.....

Registrar.

MEDICAL CERTIFICATE OF DEATH

20. DATE OF DEATH (MONTH, DAY, AND YEAR) ..... 19.....

I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19..... I last saw him alive on ..... 19.....

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

21. (a) Disease or condition directly causing death .....

(b) Antecedent causes .....

(c) Other conditions contributing to death but not related to the disease causing it .....

(d) Accident, poisoning, or violent injury .....

(e) Was injury in any way related to occupation of deceased? .....

(f) Was injury at work? .....

(g) Specify injury more definitely .....

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

Nature of injury .....

Manner of injury .....

Date of injury ..... 19.....

Place of injury .....

(State whether on premises, factory, farm, street, etc.)

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

Whether accidental, suicidal, or homicidal? .....

Did death result within 24 hours of injury? .....

Did injury occur while at work? .....

Date of injury ..... 19.....

Hour of injury .....

Place of injury .....

(State whether on premises, factory, farm, street, etc.)

Specify injury more definitely .....

Nature of injury .....

Manner of injury .....

22. DATE OF DEATH (MONTH, DAY, AND YEAR) ..... 19.....

Do not use this space

Filed No. ..... Registrar's No. .....

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.