REC'D APR 21 1939

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

12501
Do not use this space.

1. PLACE OF DEATH
(a) County Shannon 2 Registration District No.
(b) Township Alley Primary Registration District No. Registered No.
or
(c) City (d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Annica McCormac
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John McCormac
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Hsf
9. Industry or business in which work was done, as 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) Tenn

FATHER
13. NAME Joseph Davis
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) R. A. McCormac Alley Mo
18. BURIAL, CREMATION, OR REMOVAL
PLACE Alley Mo. DATE 3-4- 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Nom
20. FILED 3-4- 1939 Frank Hyde M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar-3- 19
22. I HEREBY CERTIFY, That I attended deceased from Mar-3- 1939, to Mar 3- 19
I last saw her alive on Mar-3- 1939. Death is
to have occurred on the date stated above, at 11-5 P m.
The principal cause of death and related causes of importance were as follows:

Date of onset

Cerebral Hemorrhage

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? 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, 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) Frank Hyde, M. D.
(Address) Eminence Mo.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

12501
Do not use this space.

1. PLACE OF DEATH
(a) County: Shannon Registration District No.: 824
(b) Township: Alley Primary Registration District No.: 6289 Registered No.:
(c) City: (d) Street No.: St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME: American McCormac
(a) Residence, No.: St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Wid

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

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

7. AGE: Years 82 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as 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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 3-8-, 1939 Frank Hyde M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 3, 1939.

22. I HEREBY CERTIFY, That I attended deceased from ....19.... to ...., 19.... I last saw h.... alive on ...., 19.... Death is said to have occurred on the date stated above, at ....m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	
Other contributory causes of importance:	

Name of operation .... Date of ....
What test confirmed diagnosis? .... 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 ...., 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) Frank Hyde, M. D.
(Address) Ennindee Mo

SUPPLEMENTARY

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

MAY 1 2 1939
MAY 1 2 1939