

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

33703  
Do not use this space.

1. PLACE OF DEATH *Stone*  
 (a) County *Stone* Registration District No. *1096*  
 (b) Township *Flat Creek* Primary Registration District No. *6247*  
 (c) City ..... (d) Street No. ....  
 (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 *Ruby Christine M. Cormick*  
 (a) Residence, No. *Cape Fair, Mo.* St.  (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF .....  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct 2, 1917*  
 7. AGE YEARS *21* MONTHS *11* DAYS *0* If LESS than 1 day, ..... hrs. or ..... min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Stenographer*  
 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) *Cape Fair, Mo.* (STATE OR COUNTRY) *Mo. 0*

13. NAME *Lawrence M. Cormick*  
 14. BIRTHPLACE (CITY OR TOWN) *Lawrence, Co. Mo.* (STATE OR COUNTRY) *Mo. 0*

15. MAIDEN NAME *Sarah Foster*  
 16. BIRTHPLACE (CITY OR TOWN) *Cape Fair, Mo.* (STATE OR COUNTRY) *Mo.*

17. INFORMANT *Lawrence M. Cormick* (ADDRESS) *Cape Fair, Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Cape Fair, Mo.* DATE *9/3/39*

19. FUNERAL DIRECTOR (NAME) *Wm. J. General* (ADDRESS) *Cassville, Mo.*

20. FILED *9/3/39* 19.39 *Louis Keeney* Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept 2, 1939*  
 22. I HEREBY CERTIFY, That I attended deceased from *Aug 1, 1939*, to *Sept 2, 1939*  
 I last saw *her* alive on *Aug 1, 1939*. Death is said to have occurred on the date stated above, at *12 noon*.  
 The principal cause of death and related causes of importance were as follows:

*Laryngitis T.B.*  
 Date of onset  
 Other contributory causes of importance: *77*

Name of operation *none* Date of .....  
 What test confirmed diagnosis? *Gram stain* 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. J. Keeney*, M. D.  
 (Address) *159*

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.

OCT 13 1939

*Young*

RECEIVED

District Health Officer No. 6,

District File Number 1039-1953

Date Filed OCT 5 1939

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,

*Eugene Wood*

or by

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed

*Eugene Wood*

Licensed Embalmer No.

*3804*

P. O. Address

*Cassville, Mo*

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

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