

1. PLACE OF DEATH:

(a) County Springfield GREENE  
(b) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Burge Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution less than 1 day  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence  
(c) City or town Marionville  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Mc Cormick, Wilburn Dean

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 488-16-3552

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased February 28 1908  
(Month) (Day) (Year)

8. AGE: Years 34 Months 3 Days 0 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Weiser Idaho  
(City, town, or county) (State or foreign country)

10. Usual occupation WPA

11. Industry or business \_\_\_\_\_

12. Name William B. McCormick

13. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Ella Hoodall

15. Birthplace Jay County Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ella M. McCormick  
(b) Address Marionville, Mo.

17. (a) Removed (b) Date thereof May 28 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marionville

18. (a) Signature of funeral director Belton Funeral Home  
(b) Address Marionville, Mo.

19. (a) May 28 1940 (b) W. E. Handley MD  
(Date registered local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 28  
year 1940 hour 1 minute 40 P.M.

21. I hereby certify that I attended the deceased from May 27  
1940, to May 28 1940.

that I last saw him alive on May 28 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiovascular  
Collaps (Shock) Duration \_\_\_\_\_

Due to Complication of  
Artificial fever treatment  
Due to \_\_\_\_\_

Other conditions Tuberercular  
(Include pregnancy within 3 months of death)  
and hypertension

Major findings: None PHYSICIAN \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy No autopsy 40  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
904  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature Leland F. Glavin (M. D. or other) \_\_\_\_\_  
Address 700 Medical Bldg. Date signed 5-28-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**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 comply with the above constitutes grounds for revocation of license.)**

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

