

No. 2
1-10-39
5-17-39
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FILED JUN 10 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **19459**

Registration District No. **784**

Primary Registration District No. **101**

Registrar's No. **889**

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Clayton
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis County Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 mo. 4 days
 In this community 35 years
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Edward McCormack 26.5
3. (b) If veteran, name war ?
3. (c) Social Security No. ?

4. Sex male **5. Color or race** white
6. (a) Single, widowed, married, divorced widower
6. (b) Name of husband or wife Mary Powers McCormack
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan. 18 1858
 (Month) (Day) (Year)

8. AGE: Years 82 Months 3 Days 18
 If less than one day hr. _____ min.

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

10. Usual occupation nil.

11. Industry or business _____
12. Name Michael McCormack
13. Birthplace Ross Carnow Ireland
 (City, town, or county) (State or foreign country)
14. Maiden name Jane Byrne
15. Birthplace Ross Carnow Ireland
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Winifred Shasserre
(b) Address 6435 Chatham

17. (a) Burial **(b) Date thereof** 5-9-40
 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Jos. W. Clark

(b) Address 1125 Hodiament

19. (a) MAY 7 - 1940 **(b)** [Signature]
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County St. Louis
 (c) City or town Wellston
 (If outside city or town limits, write "RURAL")
 Street No. 6435 Chatham
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? since 1879 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 6
 year 1940 hour 12 minute :40 A.M.
21. I hereby certify that I attended the deceased from 4-2-40
 _____, 19____, to 5-6-40, 19____;
 that I last saw him alive on 5-6-40, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death myocardial failure

Due to Bronchial asthma 3 yrs

Due to _____ 112

Other conditions _____
 (Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy _____
 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? _____

707 **While at work?** _____ (Specify type of place)
 _____ (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address Adair Co. Hosp. **Date signed** 5-6-40

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.