

FILED MAY 14 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

13436

State File No.

Registration District No. 377

Primary Registration District No. 1002

Registrar's No. 1751

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 19 days
(Specify whether
In this community 19 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. K.C. General Hospital No. 1
(If rural, give location)
(e) Citizen of foreign country? 614 Cambridge (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME McCormick infant

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex M. D. 5. Color or race W 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 4 - 1942
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
19 hr. min.

9. Birthplace WALKER Mo
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

12. Name JOHN LESTER MCCORMICK
13. Birthplace WALKER Mo
(City, town, or county) (State or foreign country)
14. Maiden name MILDRED MORROW
15. Birthplace KANSAS CITY Mo
(City, town, or county) (State or foreign country)

16. (a) Informant John L. McCormick
(b) Address 614 Cambridge
17. (a) Burial (b) Date thereof 5-4-42
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Sheel Funeral Home
(b) Address 606 Linden Ave
19. (a) May 4, 1942 (b) M. M. Crown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29th
year 1942 hour 7 minute 15 P. M.

21. I hereby certify that I attended the deceased from 4-10-42, 19 , to 4-29-42, 19 ,
that I last saw h. in alive on 4-29-42, 19 ,
and that death occurred on the date and hour stated above.

Immediate cause of death

PREMATURITY

Due to 159

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy

See above

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?

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

23. Signature Drew R. Thorn (M. D. or other)
Address Med. Dir. K.C. Gen. Hospital Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

341

(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

Cambridge
J. P. J. Heil

Licensed Embalmer No. *3625*

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, fact should be so stated above.