

S. No. 2
-9-4-41
5-17-39
P1 X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **32715**

FILED SEP 17 1943
29

Registration District No. _____

Primary Registration District No. **4485**

Registrar's No. **22**

1. PLACE OF DEATH:

(a) County: Scott

(b) City or town: Donipoll
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location) 1

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community, 45 years.
years, months or days (Specify whether _____)

3. (a) PRINT FULL NAME: IDA BELL MCCORMICK

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: WIDOW

6. (b) Name of husband or wife: BOB MCCORMICK

6. (c) Age of husband or wife if alive: _____ years

7. Birth date of deceased: JULY 22 1866
(Month) (Day) (Year)

8. AGE: Years 77 Months _____ Days 25 If less than one day _____ hr. _____ min.

9. Birthplace: LYON KENTUCKY
(City, town, or county) (State or foreign country)

10. Usual occupation: HOUSE WIFE

11. Industry or business: _____

MOTHER FATHER

12. Name: ALBERT MCCORMICK

13. Birthplace: UNKNOWN A
(City, town, or county) (State or foreign country)

14. Maiden name: NANCY HALL

15. Birthplace: VA
(City, town, or county) (State or foreign country)

16. (a) Informant: ARTHUR MCCORMICK

(b) Address: ILLMO MO

17. (a) BURIAL (b) Date thereof: 8/18/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: LITNER CEMITARY ILLMO MO

18. (a) Signature of funeral director: BISPLINGHOFF HUBBARD

(b) Address: ILLMO MO

19. (a) 8/18/1943 (b) Mrs W. L. Tomlinson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: MO (b) County: SCOTT 100

(c) City or town: FARMFELT 2
(If outside city or town limits, write "RURAL") 0

(d) Street No. _____ (If rural, give location) _____

(e) Citizen of foreign country? _____ (Yes or No) _____

If yes, name country: _____ 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 17
year 1943 hour 2:20 minute _____ M.

21. I hereby certify that I attended the deceased from July 24, 1943, to August 17, 1943, that I last saw her alive on August 16, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death: myocarditis

Due to: Gastroenteritis
family

Due to: _____

Other conditions: none 1/20 a
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations: ✓

Of autopsy: none

Duration _____

PHYSICIAN _____

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): no

(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) _____

23. Signature: A. Lee MD (M.D. or other) MD

Address: Illmo Mo Date signed: 8/17/43

1316 (Licensed Embalmer's Statement on Reverse Side)

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

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RECEIVED

District Health Office No. 2,

District File Number 943-1146

Date Filed 9-13-43

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, fact should be so stated above.