

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED APR 6 1944 818

Primary Registration District No. 1003

Registrar's No. 3009

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
4883 Margaretta Ave. /
(If not in hospital or institution, write street number or location)

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

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000 17

(c) City or town St., Louis 71
(If outside city or town limits, write "RURAL")

(d) Street No. 4883 Margaretta Ave.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John Robert McCormick

3. (b) If veteran, name war _____

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Minnie McCormick

6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased May 7 1871
(Month) (Day) (Year)

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

72	10	21	hr. min.
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9. Birthplace Ontario Canada 2
(City, town, or county) (State or foreign country)

10. Usual occupation Barber

11. Industry or business _____

MOTHER FATHER { 12. Name John McCormick

13. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

14. Maiden name Eileen Hussey

15. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Ursula Steinkamp

(b) Address 4882 Margaretta Ave.

17. (a) Burial (b) Date thereof 3/31/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Stroot-Carroll

(b) Address 4600 Natural Bridge

19. (a) WAR 30 30 1/2 (b) J. F. Breeseck
(Date received local health officer) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 28
year 1944 hour 4 minute 15 P. M.

21. I hereby certify that I attended the deceased from April 21
_____, 1944, to March 28, 1944;
that I last saw him in alive on March 21, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death:
Pulmonary Hemorrhage
c. asphyxia

Due to Causes of the lung.

Due to _____

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

Major findings:
Of operations H

Of autopsy _____

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) _____

(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)

(e) Means of injury _____

23. Signature William O. Mowley (M. D. or other) _____
Address 3633 Fair Ave Date signed 3/29/44

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

MAR 25 1988

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 Sheldon Collier

Licensed Embalmer No. 3382

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.