

FILED NOV 10 1944
Registration District No. 375

Primary Registration District No. 6162

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

1. PLACE OF DEATH:

(a) County STONE

(b) City or town REED-SPRINGS R-3
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 1
(Specify whether)

In this community MOST OF LIFE
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County STONE

(c) City or town REED SPRING
(If outside city or town limits, write "RURAL")

(d) Street No. RED #3.
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME WILLIAM B. M^c CORMICK

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M.O. 5. Color or race W. 6. (a) Single, widowed, married, divorced M.V.

6. (b) Name of husband or wife EVA M^c CORMICK 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased JUNE 17 1876
(Month) (Day) (Year)

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

68 2 27 hr. _____ min.

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

10. Usual occupation FARMING

11. Industry or business _____

MOTHER FATHER { 12. Name WASH M^c CORMICK

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

14. Maiden name LEE HOPPER

15. Birthplace _____ TENN.
(City, town, or county) (State or foreign country)

16. (a) Informant MRS LESTER M^c CORMICK

(b) Address GREEN FORREST ARK.

17. (a) BURIAL (b) Date thereof 9/15/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation YOKUM POND

18. (a) Signature of funeral director W. H. Noon

(b) Address 5755 VILLE DR

19. (a) 9/20/44 (b) Grace White
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept., day 14
year 1944 hour 7 A.M. minute _____ M.

21. I hereby certify that I attended the deceased from May-1944
19____, to Sept-14-1944, 19____;

that I last saw him alive on Aug. 25th, 1944, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertrophy of Right heart.

Duration 9

Due to ? 95C²

Due to _____

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

Major findings:
Of operations _____

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? _____

(Specify type of place)
While at work? _____ (c) Means of injury 0

23. Signature M. P. Kettell (M. D. or other) _____

Address Reeds Spring, Mo. Date signed _____

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 *C. M. Jones*

Licensed Embalmer No. 3453

P. O. Address Carroll, Pa.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 35505

Registration District No. 345

Primary Registration District No. 662

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Stone
 (b) City or town Rural - Ruth Jump
(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)
 (d) Length of stay: In hospital or institution _____
(Specify whether _____)
 In this community _____
years, months or days

3. (a) PRINT FULL NAME Wm B. McCormick
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: June 17 (Month) (Day) (Year)

8. AGE: Years 68 Months 2 Days _____ If less than one day _____ min.

9. Birthplace Broome, Ark (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) Feb - 4 - 1945 (b) Grace White
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Sept Day 14 Year 1944 Hour _____ Minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 19____
 that I last saw him _____ alive on _____ 19____
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Due to _____
 Due to _____
 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?
 While at work? _____ (Specify type of place) (e) Means of injury _____
 23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

