

1-2-43  
5-17-39  
X39897

Registration District No. **280**

Primary Registration District No. **5965**

Registrar's No. **40**

**1. PLACE OF DEATH:**  
 (a) County **PLATTE**  
 (b) City or town **SMITHVILLE, MO. R.F.D.**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: **HOME** *Preston Twp*  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
 In this community **LIFETIME**  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State **MO.** (b) County **PLATTE** **23**  
 (c) City or town **SMITHVILLE, R.F.D.** **3**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? **NO** (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** **WILLIAM LLOYD McCORKLE**  
 (b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **ABOUT OCT.** day **20**  
 year **1944** hour **UNKNOWN** minute \_\_\_\_\_ M.

**4. Sex** **MALE** **0** **5. Color or race** **WHITE** **6. (a) Single, widowed, married, divorced** **MARRIED**  
**6. (b) Name of husband or wife** **AGNES MURPHY McCORKLE** **6. (c) Age of husband or wife if alive** **51** years  
**7. Birth date of deceased:** **AUG.** **12** **1892**  
(Month) (Day) (Year)

**21. I hereby certify that I attended the deceased from** \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

**8. AGE:** Years Months Days If less than one day  
**52** **2** **8** \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death **GUN SHOT WOUND** ✓  
 Duration \_\_\_\_\_

**9. Birthplace:** **EDGERTON MO.**  
(City, town, or county) (State or foreign country)

Due to \_\_\_\_\_  
 Due to **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**  
 Other conditions **REQUESTED**  
(Include pregnancy within 3 months of death)

**10. Usual occupation:** **FARMER**

**11. Industry or business:** **GENERAL**  
**12. Name:** **WM. A. McCORKLE**  
**13. Birthplace:** **MO.**  
(City, town, or county) (State or foreign country)  
**14. Maiden name:** **EFFIE F. LIZAR**  
**15. Birthplace:** **MO.**  
(City, town, or county) (State or foreign country)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

**16. (a) Informant:** **RAY McCORKLE**  
**(b) Address:** **LIBERTY, MO. R.F.D.**

**22. If death was due to external causes, fill in the following:** ✓  
 (a) Accident, suicide, or homicide (specify) **UNKNOWN**  
 (b) Date of occurrence **ABOUT OCT. 20, 1944**

**17. (a) BURIAL** (b) Date thereof **10/30/44**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation **SMITHVILLE, MO.**

(c) Where did injury occur? **PLATTE MO.**  
(City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
**AT FARM HOME**

**18. (a) Signature of funeral director:** *The Coates Funeral Home*  
**(b) Address:** *Smithville, Mo.*  
**19. (a) 11-1-44** (b) *Mrs. Clay Huffer*  
(Date received by registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury \_\_\_\_\_  
**23. Signature:** *M. H. T. Hood* (M.D. or other)  
 Address *Earham* Date signed *10/29/44*

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

300



Registration District No. 280

Primary Registration District No. 5965

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

1. PLACE OF DEATH:

(a) County Platte

(b) City or town Smithville, Mo.  
(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 J. McCorkle

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 Aug 12 1894  
(Month) (Day) (Year)

8. AGE: Years 52 Months 2 Days \_\_\_\_\_  
If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

MOTHER FATHER

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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(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 Dec Day 20 year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Gun shot wound

Due to Gun in wife's hands  
held by wife

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death) 166

ADDITIONAL SUPPLEMENTARY INFORMATION

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy Body viewed Oct 29/44

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) Homicide

(b) Date of occurrence About Dec 20 1944

(c) Where did injury occur? In home Platte Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
In home on farm near Smithville Mo  
(Specify type of place)

While at work? Carriage house Means of injury Gun shot  
crosses

23. Signature W.H. Hoover (M. D. or other) \_\_\_\_\_  
Address D. Carlson 7110 Date signed 12/20/44

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