

S. No. 2
OM-5-43
v. 5-17-39
I X36671

36276

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED DEC 6 1945

Registration District No. 49

Primary Registration District No. 1002

Registrar's No. 4779

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: MEMORAH HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 DAYS
(Specify whether years, months or days) 24 years

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. 1127 TROOST AVENUE
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME DR. GILBERT COPSON McCORMICK

3. (b) If veteran, SPANISH AMER name war WORLDWARI
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 MRS. MABEL McCORMICK
6. (c) Age of husband or wife if alive 47 years
7. Birth date of deceased MARCH 29 1874
(Month) (Day) (Year)

8. AGE: Years 71 Months 7 Days 22
If less than one day hr. min.

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

10. Usual occupation PHYSICIAN

11. Industry or business _____

12. Name John Wesley McCORMICK

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

14. Maiden name Hester Copson
(City, town, or county) (State or foreign country)

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

16. (a) Informant MRS. MABEL McCORMICK

(b) Address 1127 TROOST AVENUE

17. (a) REMOVAL (b) Date thereof NOV. 23 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LACROSS KANSAS

18. (a) Signature of funeral director O. H. Anderson
(b) Address 1401 BRUSH CREEK BLVD

19. (a) 11-21-45 (b) Edw. H. Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 21 year 1945 hour 8 minute 35 A.M.
21. I hereby certify that I attended the deceased from NOV 16, 1945 to NOV 21, 1945
that I last saw h. l. m. alive on NOV 21, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Apoplexy Duration 7 days

Due to Hypertension

Due to _____

Other conditions 83a
(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? _____

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

23. Signature J. H. [unclear] (M. D. or other)

Address 1408 Argyle Bldg Date signed 11-21-45

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

488 Orange Rd
11:30-12:15, 1:30-4

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 Carl Papp

Licensed Embalmer No. 23458

P. O. Address F.C. Mo.

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.