S. No. 2
DM—2-43
v. 5-17-39
I X35697

#54208

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 30 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11389

Registration District No. ..... Primary Registration District No. 1003 Registrar's No. 2631

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

1. PLACE OF DEATH:

(a) County .....
(b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 0 (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000
(c) City or town St Louis 125
(If outside city or town limits, write "RURAL")
(d) Street No. 713 WALNUT 7
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME TOM MCCORMACK

3. (b) If veteran, name war ..... 3. (c) Social Security No. .....

4. Sex MALE 0 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED 2

6. (b) Name of husband or wife MARY 6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased Aug (Month) 15 (Day) 1860 (Year)

8. AGE: Years 85 Months 7 Days 0 If less than one day ..... hr. ..... min.

9. Birthplace ST. LOUIS (City, town, or county) 0 (State or foreign country)

10. Usual occupation PEDLER

11. Industry or business .....

FATHER
12. Name THOMAS McCORMACK
13. Birthplace ..... (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name UK
15. Birthplace ..... (City, town, or county) 9 (State or foreign country)

16. (a) Informant Mrs Joyce
(b) Address 2331 Mobile Ave
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-21-46 (Month) (Day) (Year)
(c) Place: burial or cremation CALVARY
18. (a) Signature of funeral director Cullen Kelly
(b) Address 4386 Lindell
19. (a) MAR 19 1946 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 15th year 1946 hour 7;10 minute A M.

21. I hereby certify that I attended the deceased from 2/17/46, 19..., to 3/15/46, 19...; that I last saw him alive on 3/15/46, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia
Due to arteriosclerotic Heart Disease
Due to .....
Other conditions ..... (Include pregnancy within 3 months of death) 93
Major findings:
Of operations .....
Of autopsy Same

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) .....
(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? ..... (e) Means of injury .....

23. Signature [signature] 1515 Lafayette 3/15/46 (M.D. or other)
Address ..... Date signed .....

(Licensed Embalmer's Statement on Reverse Side)

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. Howard F. Rowland

Licensed Embalmer No. 3114

P. O. Address St Louis 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.