

FILED MAR 18 1946

Registration District No. 381

Primary Registration District No. 6179

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Sullivan
(b) City or town Pollack
(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 72 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Janie Isabelle McCormick

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

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Chas McCormick 6. (c) Age of husband or wife if alive 81 years

7. Birth date of deceased Sept 27 1873
(Month) (Day) (Year)

8. AGE: Years 72 Months 4 Days 26 If less than one day hr. min.

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

10. Usual occupation House wif

11. Industry or business _____

MOTHER, FATHER

12. Name Eliqa Burkhardt

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

14. Maiden name Anna Kartestain

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

16. (a) Informant Chas McCormick

(b) Address Pollack Mo

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 2 26-46 (Month) (Day) (Year)

(c) Place: burial or cremation Scobee - Pollack Mo

18. (a) Signature of funeral director Schoenes

(b) Address Millin Mo

19. (a) March 2-46 (Date received local registrar) (b) Mrs. H. B. Harris (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Sullivan 105
(c) City or town Pollack (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 23 year 1946 hour 8 minute _____ a. M.

21. I hereby certify that I attended the deceased from Feb 22, 1946, to Feb 23, 1946, that I last saw her alive on Feb 23, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 2 days

Due to Hypertension + arteriosclerosis 20 year

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

Major findings: Of operations § 30

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) _____ Means of injury _____

23. Signature Chas L. [unclear] (M. D. or other) D.D.

Address W. Manville Mo Date signed 2-24-46

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

RECEIVED

District Health Officer No. 10

District File Number 3-46-523

Date Filed MAR 16 1946

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..... Dwight Schauer.....

Licensed Embalmer No..... 2667.....

P. O. Address..... Melan. 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.