

FILED DEC 24 1946

Registration District No. 777

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town K. C.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Con. Home 623 Euclid **4**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 Months
In this community 20 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson **48**
(c) City or town Kansas City **3**
(If outside city or town limits, write "RURAL")
(d) Street No. 1914 E. 43rd **8**
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____ **7**

3. (a) PRINT FULL NAME Frank George McCormick Sr.

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex M 5. Color of race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife Anna McCormick 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 31, 1863
(Month) (Day) (Year)

8. AGE: Years 83 Months 4 Days 6 If less than one day hr. _____ min. _____

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

10. Usual occupation Retired R. R. Mail Carrier

11. Industry or business U. S. Government

MOTHER FATHER { 12. Name George McCormick
13. Birthplace Scotland
(City, town, or county) (State or foreign country)
14. Maiden name Sarah
15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant F. G. McCormick
(b) Address 906 E. 29th Street

17. (a) Burial (b) Date thereof 12-10-46 2P
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Washington

18. (a) Signature of funeral director C. H. Blackman & Son, Inc

(b) Address 2825 Independence Blvd.

19. (a) 12-10-46 (b) Heraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 7
year 46 hour 8 minute 45 P.M.

21. I hereby certify that I attended the deceased from _____ to Dec 7 1946
that I last saw him alive on Dec 7 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis **47**

Due to Hypertension
Due to Senility

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 93rd
Of autopsy _____

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 S. D. Ramer (Physician)
Address 900 Benton St Date signed 12-9-46

PHYSICIAN
Underline the cause to which death should be charged statistically.

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 Q. K. McFarland
Licensed Embalmer No. 4397
P. O. Address Kansas City

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.