

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 27 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18149

State File No. _____

Registration District No. 209

Primary Registration District No. 4320

Registrar's No. 30

1. PLACE OF DEATH:

(a) County Marion

(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: County Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 years
(Specify whether years, months or days)

In this community Fifty
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion ⁶⁴

(c) City or town Rural
(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 THOMAS M^c CORMIC

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 28
year 1947 hour 7 minute A.M.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced S.

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive 5 years

7. Birth date of deceased May 18 1866
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April 1, 1947 to _____, 19____;

that I last saw him alive on April 21, 1947; and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>11</u>	<u>20</u>	hr. _____ min. _____

Immediate cause of death Myocarditis
Chronic nephritis

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

Due to Prostate Hypertrophy

Due to _____

10. Usual occupation Laborer

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

11. Industry or business _____

MOTHER FATHER } 12. Name Roger M^c Cormic

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

14. Maiden name Kate Pagan

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

Major findings: Of operations 1313

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Hospital Records

(b) Address Marion Co Mo

17. (a) burial (b) Date thereof 4-30-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Catholic Cemetery

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? _____

18. (a) Signature of funeral director R M Spague

(b) Address Palmira Mo

19. (a) 5-5-1947 (b) Viola Keen
(Date received local registrar) (Registrar's signature)

While at work _____ (Specify type of place)

(c) Means of injury _____

23. Signature R M Spague (M. D. or other) M.D.

Address Marion Date signed 4-28-47

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

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 *A. M. Sprague*
Licensed Embalmer No. *999*
P. O. Address *Palmyra 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.

Registration District No. 209

Primary Registration District No. 4320

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(a) County Marion
(b) City or town Rural
(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)

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.....

3. (a) PRINT FULL NAME Thomas McCormac

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 Single

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

7. Birth date of deceased May 18
(Month) (Day) (Year)

8. AGE: Years 80 Months 11 Days 22
If less than one day, hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 28
year 1947 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 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.....

Due to.....

Due to.....

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

Major findings:
Of operations.....

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..... (M. D. or other)

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

18149