S. No. 2
I—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41786

FILED JAN 13 1948

Registration District No. 199

Primary Registration District No. 1002

Registrar's No. 5533

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town K.C. General Hospital
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution 4 Days 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 27 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 2017 Linwood 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Thomas Floyd McCormick

3. (b) If veteran, name war No

3. (c) Social Security No. 486-10-5046

4. Sex Male 0

5. Color or race Wh.

6. (a) Single, widowed, married, divorced Div. 3

6. (b) Name of husband or wife unknown.

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

7. Birth date of deceased June 19 1883
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
64	6	10	..... hr. ..... min.

9. Birthplace Sullivan Cty. Mo 0
(City, town, or county) (State or foreign country)

10. Usual occupation Guard

11. Industry or business .....

FATHER
12. Name Thomas McCormick 1
13. Birthplace Ky.
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Tolles 0
15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant James McCormick
(b) Address Milan Mo

17. (a) Milan Mo (b) Date thereof Jan 1 1948
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation (Burial) Milan Mo

18. (a) Signature of funeral director Wornall Funeral Home
(b) Address Kansas City Mo

19. (a) 12-31-47 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 29
year 1947 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from .....
....., 19....., to ....., 19.....;
that I last saw h..... alive on ....., 19.....;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Subarachnoid	
Due to Hemorrhage	
Due to Cerebral Encephalomalcia	
Other conditions (Include pregnancy within 3 months of death) Pending	
Major findings: Of operation Deputy Coroner	
Of autopsy See Above	

PHYSICIAN

Underline the cause of 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? ..... Means of injury .....

23. Signature A. E. Ascher M.D. (M. D. or other)

Address 2800 Main Date signed 12/29/47

Jefferson City Printing Co. (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 Kenneth R. Royer, Registered Apprentice No. 63, working under my personal supervision.

Signed Howard G. Roe

Licensed Embalmer No. 2748

P. O. Address K C Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
25M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 20 1948

Registration District No. 199

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Primary Registration District No. 1002.

Registrar's No. 5533

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: Gen. Hosp.
(If not in hospital or institution, write street number or location)

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

In this community .....

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 Floyd McCormick

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex .....

5. Color or race .....

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

6. (b) Name of husband or wife .....

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

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

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

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

10. Usual occupation .....

11. Industry or business .....

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

MOTHER
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) 12-31-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. Day 29 year 1947 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..... ; that I last saw him alive on ..... 19..... ; and that death occurred on the date and hour stated above.

Immediate cause of death Subarachnoid hemorrhage — Duration

Due to Cerebral encephalomalacia

Due to injury by fall

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

Major findings:
Of operations 1 Rt a 38

Of autopsy see above

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) Accident

(b) Date of occurrence 12-25-47

(c) Where did injury occur? K.C. Jackson Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public place (Specify type of place)

While at work? no (e) Means of injury trauma

23. Signature A. E. Upshaw (M. D. or other)

Address 2800 Main Date signed 12-29-47

SUPPLEMENTARY

41786