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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 11 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29304

Registration District No. _____

Primary Registration District No. 4153

Registrar's No. 79

1. PLACE OF DEATH:

(a) County Dade
(b) City or town Lockwood
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 10 yrs. (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Dade
(c) City or town Lockwood, Mo.
(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

Willard I. Corrick

3. (b) If veteran, name war 1 3. (c) Social Security No. 1

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

6. (b) Name of husband or wife Elizabeth Corrick 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Feb 3 1879
(Month) (Day) (Year)

8. AGE: Years 70 Months 7 Days 23 If less than one day _____ hr. _____ min.

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

10. Usual occupation Cafe Operator

11. Industry or business _____

12. Name Unkown

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

14. Maiden name Unkown

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

16. (a) Informant Mrs. Elizabeth Corrick

(b) Address Lockwood, Mo.

17. (a) Burial (b) Date thereof Sept. 29, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lockwood Cemetery

18. (a) Signature of funeral director W.R. Allison
Greenfield, Mo.

(b) Address _____

19. (a) 9-30-48 (b) Geo L. Weir
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEP day 27
year 1948 hour 7 minute A M.

21. I hereby certify that I attended the deceased from July 1948 to SEP 1948
that I last saw him alive on SEP 20 1948
and that death occurred on the date and hour stated above.

Immediate cause of death COLONIAL THROMBOSIS

Due to ARTERIOSCLEROSIS

Due to _____

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

Major findings: Of operations _____

Of autopsy 940

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Frank H. Binner (M. D. or other) _____

Address Medical Mo Date signed 9/28/48

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

MOTHER FATHER

RECEIVED

District Health Officer No. 6;

District File Number 1048-1121

Date Filed 10-9-48

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.....

George W. Newcomb

Registered Apprentice No. 30

working under my personal supervision.

Signed W. R. Allison

Licensed Embalmer No. 2404

P. O. Address Greenfield, 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. 93 Primary Registration District No. 4153

1. PLACE OF DEATH:

(a) County Lackwood Pade
 (b) City or town Lackwood town
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Home
(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)

3. (a) PRINT FULL NAME Willard J Corrick

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 m

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

7. Birth date of deceased July 3
(Month) (Day) (Year)

8. AGE: Years 70 Months 7 Days 27 If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____
 13. Birthplace Jawa Jawa
(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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____

13. (a) Signature of funeral director _____
 (b) Address _____

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

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day 27
 year 1948 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) (c) Means of injury

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

SUPPLEMENTARY

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

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

S-29304