

FILED OCT. 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **35368**
Registrar's No. **8939**

#103486

REG. DIST. NO. **318**PRIMARY REG. DIST. NO. **1003**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 35368		Registrar's No. 8939	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo.</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		d. STREET ADDRESS (If rural, give location) <u>21 2330 Olive</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis City Hospital #1.</u>				3. NAME OF DECEASED a. (First) <u>WILLIAM</u> b. (Middle) _____ c. (Last) <u>MCCORMACK</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 17th, 1949</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Jan. 17, 1871</u>		9. AGE (In years last birthday) <u>78</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 14 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? _____			
13a. FATHER'S NAME <u>William McCormack</u>			13b. MOTHER'S MAIDEN NAME <u>Margaret Fox</u>			14. NAME OF HUSBAND OR WIFE <u>Norah</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If no, give war or dates of service) <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Agnes McCormack</u> ADDRESS <u>8907</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Prostate</u> INTERVAL BETWEEN ONSET AND DEATH _____ ANTECEDENT CAUSES DUE TO (b) <u>Genl. Carcinomatosis.</u> DUE TO (c) <u>arteriosclerosis, Genl.</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>51</u>		21f. HOW DID INJURY OCCUR? <u>fall</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from <u>9/10/49</u> , 19 <u>49</u> , to <u>10/17/49</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>10/17/49</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>Walker M. Turner, M.D.</u>				23b. ADDRESS <u>1515 Lafayette Ave.,</u>		23c. DATE SIGNED <u>10/17/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE <u>10-20-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Culinary</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>OCT 18 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Casater</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Neuhart</u> ADDRESS <u>1431 Union</u>					

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed Frank A. Nicholas

Licensed Embalmer No. 2915

P. O. Address _____

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

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