

FILED MAY 1 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13837

BIRTH NO. _____ REG. DIST. NO. 217 PRIMARY REG. DIST. NO. 3045 Registrar's No. 32

1. PLACE OF DEATH a. COUNTY Mississippi			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Mississippi		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Charleston		c. LENGTH OF STAY (in this place) 34 Yrs	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Charleston		
d. FULL NAME OF HOSPITAL OR INSTITUTION			d. STREET ADDRESS (If rural, give location) 303 N. Johnson		

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Fonzie	b. (Middle) Mayhew	c. (Last) McCormick	(Month) April	(Day) 9	(Year) 1950

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept 15, 1874	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
--------------------	-------------------------------	---	---------------------------------------	---	---------------------------	--------------------------	--------------------------	-------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Decatur County, Tennessee	12. CITIZEN OF WHAT COUNTRY? USA
--	---	---	--

13a. FATHER'S NAME Samuel David McCormick	13b. MOTHER'S MAIDEN NAME Leora Liston	14. NAME OF HUSBAND OR WIFE Mary Ann McCormick
---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Mr. W. David McCormick, Charleston, Mo	ADDRESS
---	--	--	---------

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		INTERVAL BETWEEN ONSET AND DEATH DK DK 4221
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ventricular Fibrillation		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chr. Myocarditis DUE TO (c) Arterio-sclerosis		

19a. DATE OF OPERATION none	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)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from April 5, 1950, to April 8, 1950, that I last saw the deceased alive on April 8, 1950, and that death occurred at 3:20A m., from the causes and on the date stated above.

23a. SIGNATURE L. Charles Polwing	(Degree or title) M.D.	23b. ADDRESS Charleston, Mo.	23c. DATE SIGNED 4/10/1950
---	----------------------------------	--	--------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4/10/1950	24c. NAME OF CEMETERY OR CREMATORY odd fellows Cem. Charleston, Mo	24d. LOCATION (City, town, or county) (State) Charleston, Missouri
--	-------------------------------	--	--

DATE REC'D BY LOCAL REG. April 21, 1950	REGISTRAR'S SIGNATURE Mrs. Lex Kilgore	4395 FUNERAL DIRECTOR'S SIGNATURE THE SUNNYSIDE FUNERAL CHAPEL	ADDRESS Charleston, Mo
---	--	--	----------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

0677

APR 28 RECEIVED
RECEIVED

Miss. Co. Health Dept

County File No. _____

Date Filed APR 28 1950

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 John F. Annelle
Licensed Embalmer No. 3851

P. O. Address Charleston, S.C.

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.