

FILED SEP 11 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27578

672
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

BIRTH NO. _____		REG. DIST. NO. <u>217</u>		PRIMARY REG. DIST. NO. <u>3045</u>		Registrar's No. <u>52</u>	
1. PLACE OF DEATH a. COUNTY <u>Mississippi</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> <u>Mississippi</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Charleston</u>		c. LENGTH OF STAY (in this place) <u>34 years</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Charleston, Mo</u>		<u>0692</u> <u>0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>303 Johnson St.,</u>				d. STREET ADDRESS (If rural, give location) <u>303 Johnson St.,</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Mary</u>		b. (Middle) <u>Ann</u>		c. (Last) <u>McCormick</u>	
4. DATE OF DEATH		(Month) <u>June</u>		(Day) <u>30,</u>		(Year) <u>1950</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u> <u>2</u>		8. DATE OF BIRTH <u>November 2, 1872</u>	
9. AGE (In years last birthday) <u>77</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Henry County, Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Bart Eaves</u>		13b. MOTHER'S MAIDEN NAME <u>No Record</u>		14. NAME OF HUSBAND OR WIFE <u>Fonzie Mayhew McCormick (Decd)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>David McCormick, Charleston, Mo</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypertension heart disease</u>					
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u>					
		DUE TO (c) _____				<u>1413X A</u>	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Prob. Tubercular</u>				<u>P.K</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>				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 <u>April 5, 1950</u> , to <u>June 30, 1950</u> , that I last saw the deceased alive on <u>June 12, 1950</u> , and that death occurred at <u>8:15 Pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>E. Charles Kolmaring</u>		(Degree or title) <u>M. D. O</u>		23b. ADDRESS <u>Charleston, Mo</u>		23c. DATE SIGNED <u>8/5/50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7/2/1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Charleston, Mo</u>	
DATE REC'D BY LOCAL REG. <u>Sept 3, 1950</u>		REGISTRAR'S SIGNATURE <u>Dr. L. H. Kilgore</u>		439 1		25. FUNERAL DIRECTOR'S SIGNATURE <u>John F. ...</u>	
				THE NURNEL CO. FUNERAL CHAPEL, Charleston MO			

SEP 7 - REC'D

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Miss. Co. Health D

County File No. _____

Date Filed SEP 8 19__

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. Munnelle

Licensed Embalmer No. 3851

P. O. Address Charleston, 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.