

# STANDARD CERTIFICATE OF DEATH

State File No. **29195**

FILED AUG 28 1951

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **322** PRIMARY REG. DIST. NO. **6088** Registrar's No. **20**

**1. PLACE OF DEATH**  
 a. COUNTY **Saline**  
 b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **R.F.D. Marshall**  
 c. LENGTH OF STAY (In this place) **60 yrs**  
 d. FULL NAME OF HOSPITAL OR INSTITUTION **Thomas Johnson**

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission)  
 a. STATE **Mo.** b. COUNTY **Saline**  
 c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **R.F.F. Marshall**  
 d. STREET ADDRESS (If rural, give location) **1670**

**3. NAME OF DECEASED**  
 a. (First) **Thomas** b. (Middle) **Johnson** c. (Last) **McCormick**

**4. DATE OF DEATH** (Month) **Aug** (Day) **22** (Year) **1951**

**5. SEX** **male**  
**6. COLOR OR RACE** **white**

**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify) **married**

**8. DATE OF BIRTH** **Nov. 6, 1876**

**9. AGE** (In years last birthday) **74** IF UNDER 1 YEAR: Months **9** Days **16** IF UNDER 24 HRS. **16**

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) **farmer**

**10b. KIND OF BUSINESS OR INDUSTRY** **active**

**11. BIRTHPLACE** (State or foreign country) **Ohio.**

**12. CITIZEN OF WHAT COUNTRY?** **U S**

**13a. FATHER'S NAME** **John McCormick**

**13b. MOTHER'S MAIDEN NAME** **Ann Johnson**

**14. NAME OF HUSBAND OR WIFE** **Bertha McCormick**

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) **no** (If yes, give war or dates of service) **no**

**16. SOCIAL SECURITY NO.** **no**

**17. INFORMANT'S SIGNATURE OR NAME** **Mrs. Bertha McCormick** ADDRESS **Slater Mo.**

**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, asthma, etc. It means the disease, injury, or complication which caused death.

**MEDICAL CERTIFICATION**  
**I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\*** (a) **Carcinoma of Prostate with metastasis into urinary bladder and liver**  
**ANTECEDENT CAUSES**  
 Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  
 DUE TO (b) **metastasis into urinary bladder and liver**  
 DUE TO (c) **bladder and liver**  
**II. OTHER SIGNIFICANT CONDITIONS\***  
 Conditions contributing to the death but not related to the disease or condition causing death.

**INTERVAL BETWEEN ONSET AND DEATH** **1 yr.**

**19a. DATE OF OPERATION**

**19b. MAJOR FINDINGS OF OPERATION** **177x**

**20. AUTOPSY?** YES  NO

**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) (m.)

**21e. INJURY OCCURRED** WHILE AT WORK  NOT WHILE AT WORK

**21f. HOW DID INJURY OCCUR?**

**22. I hereby certify that I attended the deceased from 5-3, 1947, to 8-22, 1951, that I last saw the deceased alive on 8-13, 1951, and that death occurred at 10:45 p.m., from the causes and on the date stated above.**

**23a. SIGNATURE** (Degree or title) **V.A. McBurney M.D.**

**23b. ADDRESS** **Slater, Mo.**

**23c. DATE SIGNED** **8/23/51**

**24a. BURIAL, CREMATION, REMOVAL** (Specify) **Burial**

**24b. DATE** **8/24/51**

**24c. NAME OF CEMETERY OR CREMATORY** **Slater City**

**24d. LOCATION** (City, town, or county) (State) **Slater, Mo.**

**DATE REC'D BY LOCAL REG.** **8/24/51**

**REGISTRAR'S SIGNATURE** **Mrs. Earl C. Hill**

**25. FUNERAL DIRECTOR'S SIGNATURE** **Hill Brothers** ADDRESS **Slater Mo.**

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

970

**RECEIVED** 8-27-51  
DISTRICT HEALTH OFFICE No. 3  
District File Number .....  
Date Filed 8-27-51 .....

**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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....  
Student Embalmer

Signed A. C. Hill.....

Licensed Embalmer No. 3090.....

P. O. Address Station 740.....

**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.