

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

4606

State File No.

FILED JAN 20 1953

BIRTH NO. _____		REG. DIST. NO. <u>360</u>		PRIMARY REG. DIST. NO. <u>6225</u>		Registrar's No. <u>5</u>		
1. PLACE OF DEATH a. COUNTY <u>Vernon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jasper</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Washington Township</u>		c. LENGTH OF STAY (in this place) <u>1yr 3m 23d</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Carthage</u>		0493		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital 3 Nevada Mo</u>				d. STREET ADDRESS (If rural, give location) <u>515 East Highland St.</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>WILLIAM</u> b. (Middle) <u>R</u> c. (Last) <u>MCCORMICK</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 11 1953</u>					
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept 9, 1875</u>		9. AGE (in years last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>2</u>	IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>grocer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>John P. Mc Cormick</u>		13b. MOTHER'S MAIDEN NAME <u>Angelina Jaggart</u>		14. NAME OF HUSBAND OR WIFE <u>Bessie E. Mc Cormick</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Records State Hospital 3 Nevada Mo</u> 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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchial Pneumonia</u>				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>491X</u>				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerotic Heart Disease</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) <u>no</u>		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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____				
22. I hereby certify that I attended the deceased from <u>Sept 19</u> , 1951, to <u>Jan 11</u> , 1953, that I last saw the deceased alive on <u>Jan 11</u> , 1953, and that death occurred at <u>9:05 p.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Paul L. Barone M.D.</u>				23b. ADDRESS <u>State Hospital 3 Nevada Mo</u>		23c. DATE SIGNED <u>Jan 11/53</u>		
24a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		24b. DATE: <u>1-14-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Park Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Carthage Mo</u>			
DATE REC'D BY LOCAL REG. <u>1-16-1953</u>		REGISTRAR'S SIGNATURE <u>Anna E. Foy</u>		451		25. FUNERAL DIRECTOR'S SIGNATURE <u>Kneel Mortuary - Carthage Mo</u> ADDRESS _____		

(Licensed Embalmer's Statement on Reverse Side)

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

80
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MAR 2 1958

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 _____

Robert H. Knell

Licensed Embalmer No. 4459

P. O. Address _____

Carthage

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.