

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15959**
Registrar's No. **3743**

FILED APR 23 1953

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. 3743	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2169	
d. FULL NAME OF HOSPITAL OR INSTITUTION Little Sisters of the Poor				d. STREET ADDRESS (If rural, give location) 3400 S. Grand Blvd.			
3. NAME OF DECEASED (Type or Print) a. (First) Hugh		b. (Middle) E.		c. (Last) Mc Cormick		4. DATE OF DEATH (Month) (Day) (Year) April 8, 1953	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH November 2, 1879	
9. AGE (In years last birthday) 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Delivery Man		11. BIRTHPLACE (City and State or Foreign Country) Senceka, Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Delivery Man		10b. KIND OF BUSINESS OR INDUSTRY Central Optical Co.		11. BIRTHPLACE (City and State or Foreign Country) Senceka, Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Robert Mc Cormick		13b. MOTHER'S MAIDEN NAME Mary Farlin		14. NAME OF HUSBAND OR WIFE Anna Mc Cormick			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. 496-14-7954		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Anna Mc Cormick 3220 A Cherokee St.			
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) Coronary Insufficiency Arterio Sclerosis DUE TO (b) Arterio Sclerosis DUE TO (c) Arterio Sclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arterio Sclerosis				INTERVAL BETWEEN ONSET AND DEATH 1 3/4 2 3/4	
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) _____		21d. HOW DID INJURY OCCUR? H201	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? H201			
22. I hereby certify that I attended the deceased from Mar. 1953 , to 4-8 , 1953, that I last saw the deceased alive on 4-8 , 1953, and that death occurred at 5:30A m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) John H. Gebken		23b. ADDRESS 607 No Grand		23c. DATE SIGNED 4/9/53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 4/10/53		24c. NAME OF CEMETERY OR CREMATORY St. Hope Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE APR 9 1953		REGISTRAR'S SIGNATURE J. Earl Smith, MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John H. Gebken Sons 2630 Gravois Ave.			

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 Robert F. Gibson.....

Licensed Embalmer No. 4144.....

P. O. Address 2630 Gravois Ave......

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.