Health, Welfare, Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004114
STATE FILE NUMBER

FILED FEB 13 1959

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 19

1. PLACE OF DEATH
a. COUNTY Scott
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Sikeston — Inside Limits Yes ☑ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 129 No. Handy — Length of stay in 1b 18 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Scott
c. CITY OR TOWN Sikeston 1603 — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 129 No. Handy — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First Enoch Middle Zachariah Last McCormick

4. DATE OF DEATH Month Day Year 1-29-1959

5. SEX Male
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 12-25 1879
9. AGE (In years last birthday) 79 — IF UNDER 1 YEAR Months 1 Days 4 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (City and state or country) Oran, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Unknown
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE —

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.
17. INFORMANT Bertha Cantrell — Address Sikeston Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Emphysema, pulmonary Bilateral.
INTERVAL BETWEEN ONSET AND DEATH Unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____ 5271
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
(1) Secondary infection superimposed on primary. (2) Chronic Right heart failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased ~~from~~ on 1.28.59, to ____ and last saw her/him alive on 1.28.59
Death occurred at 5:15 am m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [illegible]
22b. ADDRESS Sikeston, Mo.
22c. DATE SIGNED 1.30.59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 1-31-1959
23c. NAME OF CEMETERY OR CREMATORY Carpenter Cem.
23d. LOCATION (City, town, or county) (State) Sikeston, Mo

24. FUNERAL DIRECTOR ADDRESS Allerton Funeral Home Sikeston, Mo.
25. DATE RECD. BY LOCAL REG. 2-3-59
26. REGISTRAR'S SIGNATURE Mrs Ella Hunter

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be [illegible]. All diseases in Part I must be causally related.

OCT 20 1959

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 .....
Signature of Student Embalmer

Signed Raymond L. Duffee

Licensed Embalmer No. H798

P. O. Address Dennis, M

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.