Health, Welfare Public Service

300
1-57

FILED FEB 27 1959

THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

59-005717
STATE FILE NUMBER 766

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital — Length of stay in 1b 2 weeks

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS 4089 9th (If outside, give location) — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First FRANCIS Middle X Last McCORMICK

4. DATE OF DEATH: Month 2 Day 5 Year 59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: 11-21-1891
9. AGE (In years last birthday): 67 — 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): "unknown"
10b. KIND OF BUSINESS OR INDUSTRY: "unknown"
11. BIRTHPLACE (City and state or country): St.Louis,Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: Edward Thomas McCormick
13b. MOTHER'S MAIDEN NAME: Margaret Mary "unknown"
14. NAME OF HUSBAND OR WIFE: Agnes McCormick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW 1
16. SOCIAL SECURITY NO.: 354-09-9025A
17. INFORMANT: Leo F. McCormick Address: 35 Rissant St.Louis Missouri

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) Cancer of lung — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

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 2-4-59, to 2-5-59 and last saw her/him alive on 2-5-59
Death occurred at 1:10 AM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Abraham Gelperin (Degree or title) M.D.
22b. ADDRESS 24th & Cherry
22c. DATE SIGNED 2-5-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 2-10-1959
23c. NAME OF CEMETERY OR CREMATORY: National Military Cem.
23d. LOCATION (City, town, or county) (State): Ft.Leavenworth,Kansas

24. FUNERAL DIRECTOR ADDRESS: Weilert Funeral Homes(S)K.C.,Mo.
25. DATE RECD. BY LOCAL REG.: 2-10-59
26. REGISTRAR'S SIGNATURE: Neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 B. E. Weilert

Licensed Embalmer No. 4075

P. O. Address K.C.S. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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