

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009071
STATE FILE NUMBER

WED MAR 23 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 289

300
-57
3

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Springfield</u> ^{0 37^E 0} Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Shg. Bah. Hosp.</u>		Length of stay in lb <u>5 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>2511 Albertha</u> Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>O. O. G.</u> Middle <u>O.</u> Last <u>McCormack</u>			4. DATE OF DEATH Month <u>Mar.</u> Day <u>17</u> Year <u>1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 4, 1878</u>
9. AGE (In years last birthday) <u>81</u>		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) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and state or country) <u>Webster County, Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>Pleas McCormack</u>	
13b. MOTHER'S MAIDEN NAME <u>Sally Ausment</u>		14. NAME OF HUSBAND OR WIFE <u>Norah McCormack (Dec.)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT (Doc.) <u>Noris Stubblefield</u> Address <u>Springfield, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u>
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) <u>4200</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in PART I or PART II of item 18.) <u>4200</u>	
20c. TIME OF INJURY Hour _____ o.m. _____ p.m. _____		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
20e. CITY, TOWN, OR LOCATION _____		20f. COUNTY STATE _____	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21. I attended the deceased from <u>Nov 14, 1958</u> to <u>March 17, 59</u> and last saw him <u>live</u> on <u>Nov 14, 1958</u> Death occurred at <u>3:45 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>E. O. Callaway, Jr. M.D.</u> (Degree or title)		22b. ADDRESS <u>Springfield, Mo</u>	22c. DATE SIGNED <u>Mar 20, 59</u>
23a. BURIAL, CREMATION, REBURYAL (Specify)	23b. DATE <u>3-21-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Danforth Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Greene County, Missouri</u>
24. FUNERAL DIRECTOR <u>Rex Rainey-Springfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>3-20-59</u>	26. REGISTRAR'S SIGNATURE <u>Effie G. Melton</u>

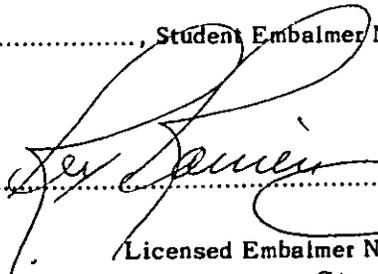
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Decadry, coroner, etc. must use any standard nomenclature with view to the symptoms with which the disease in Part I must be causally related.

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  _____
Licensed Embalmer No. 3512
P. O. Address Springfield, 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.