

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-031437
STATE FILE NUMBER

REGISTRATION DISTRICT No. 241 Primary Registration District No. 4360 Registrar's No. 27

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Portageville</u>		Length of stay in 1b		c. CITY OR TOWN <u>Portageville</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>The Clinic</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Portageville</u>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cathy</u> Middle <u>Sue</u> Last <u>McCormick</u>				4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1960</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>7-29-60</u>		9. AGE (last birthday) IF UNDER 1 YEAR Months <u>4</u> Days <u>8</u> Hours <u>4</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY <u>Clinic</u>		11. BIRTHPLACE (City and state or country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>William McCormick</u>			13b. MOTHER'S MAIDEN NAME <u>Georgia Rogers</u>			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 <u>William McCormick</u> Address				
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>Respiratory Obstruction</u> DUE TO (b) <u>Aspiration of meconium</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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.)					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>Portageville New Madrid Mo.</u> COUNTY <u>NEW MADRID</u> STATE <u>MO.</u>			
21. I attended the deceased from <u>29 July 60</u> on the date stated above, and to the best of my knowledge, from the causes stated. Death occurred _____ on the date stated above, and to the best of my knowledge, from the causes stated.								21. I last saw her/him alive on <u>29 July 60</u>	
22a. SIGNATURE (Degree or title) <u>William McCormick MD</u>				22b. ADDRESS <u>Portageville Mo</u>				22c. DATE SIGNED <u>12 Aug 60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>July 29, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Portageville</u>		23d. LOCATION (City, town, or county) <u>Portageville Missouri</u>		23e. STATE <u>Missouri</u>	
24. FUNERAL DIRECTOR <u>Joseph A Delisle</u> ADDRESS <u>Portageville</u>			25. DATE RECD. BY LOCAL REG. <u>Aug 13, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Ellen D. Milum</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Not Embalmed, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.