RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS OCT 26 1960 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10017

60-039957 STATE FILE NUMBER

NDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS Mo
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 2869 SALENA
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY
c. CITY OR TOWN: ST. LOUIS
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 2869 SALENA
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First EDWARD Middle McCORMACK Last
4. DATE OF DEATH: Month OCT. Day 14 Year 1960
5. SEX: MAle
6. COLOR OR RACE: WHITE
7. Married ☑ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: JUNE 10 1889
9. AGE (last birthday): 71
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CONFECTIONERY
10b. KIND OF BUSINESS OR INDUSTRY: OWNER
11. BIRTHPLACE (City and state or country): TEXAS
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: EDWARD McCORMACK
13b. MOTHER'S MAIDEN NAME: UNKNOWN
14. NAME OF ~~HUSBAND~~ OR WIFE: MABEL McCORMACK
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: MABEL McCORMACK Address: 2869 SALENA

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) Coronary artery disease with myocardial degeneration. — INTERVAL BETWEEN ONSET AND DEATH: 2 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerotic cardiovascular disease — over 2 years
DUE TO (c) 420.1

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. ☐ Yes ☐ No ☐ Unknown

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 12 Aug. 1958 to 14 Oct. 1960 and last saw ~~the~~ him alive on 14 Oct. 1960
Death occurred at 8:13 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Robert L. Nye, M.D. (Degree or title)
22b. ADDRESS: 3201 Arsenal St. St. Louis Mo.
22c. DATE SIGNED: 15 Oct. 1960

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: OCT. 17 1960
23c. NAME OF CEMETERY OR CREMATORY: OAK HILL CEM.
23d. LOCATION (City, town, or county) (State): ST. LOUIS Co. Mo.

24. FUNERAL DIRECTOR: Thomas Kutis ADDRESS: 2906 Gravois
25. DATE RECD. BY LOCAL REG.: OCT 17 1960
26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.

DOCUMENT

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

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____ Signed Eleuan Province

Signature of Student Embalmer

Licensed Embalmer No. 3403

P. O. Address 2906 Gran

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to cor 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.