

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-008407

DEPARTMENT OF PUBLIC HEALTH AND WELFARE 318

1003

Registrar's No.

2048

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

FILED FEB 23 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE *Mo* b. COUNTY *Greene*

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN *St. Louis* Length of stay in 1b *1 mo*

c. CITY OR TOWN *Springfield* Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION *Erico Employees Hospital* Inside Limits Yes No

d. STREET ADDRESS (If outside, give location) *2006 N. Douglas* Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
Cecil Ray McCormick

4. DATE OF DEATH Month Day Year
Feb 18, 1962

5. SEX *Male*

6. COLOR OR RACE *White*

7. Married Never Married Widowed Divorced

8. DATE OF BIRTH *Oct. 29, 1904*

9. AGE (last birthday) *54 yr*

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Foreman of Car Shops*

11. BIRTHPLACE (City and state or country) *Duncan, Mo*

12. CITIZEN OF WHAT COUNTRY *U-S-A*

13a. FATHER'S NAME *Andrew McCormick*

13b. MOTHER'S MAIDEN NAME *Ada Allen*

14. NAME OF HUSBAND OR WIFE *Dora Whitlock McC*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) *No*

16. SOCIAL SECURITY NO. *Unknown*

17. INFORMANT *Wife* Address *Same*

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) *Congestive Heart Failure due to Rheumatic Heart Disease*
DUE TO (b) *416x*
DUE TO (c) *416x*
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

INTERVAL BETWEEN ONSET AND DEATH *Known 4 mo.*

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 *Jan. 18, 1962* to *Feb 18, 1962* and last saw him alive on *2-18-62*
Death occurred at *1:20 p* on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) *Norman Miller MD*

22b. ADDRESS *2960 Laclede Ave*

22c. DATE SIGNED *2-18-62*

23a. BURIAL, CREMATION, REMOVAL (Specify) *Removal*

23b. DATE *2-19-62*

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county) (State) *Springfield, Mo.*

24. FUNERAL DIRECTOR ADDRESS *Klingner Funeral Home, Springfield, Mo.*

25. DATE RECD. BY LOCAL REG. *FEB 19 1962*

26. REGISTRAR'S SIGNATURE *Coal Smith, M.D.*

USE BLACK INK OR TYPEWRITER RIBBON

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 Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address St Louis 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.