MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

V. S. No. 2.

Bohling

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Pettis

Township ________ Registration District No. 668 File No. 32007

or

Village ________ Primary Registration District No. 3032 Registered No. 245

or

City Pettis (No. 1519 S Vermont St.; ________ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Massena M McCormick

PERSONAL AND STATISTICAL PARTICULARS		
SEX: M	COLOR OR RACE: W	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): married
DATE OF BIRTH: May 28, 1827 (Month) (Day) (Year)		
AGE: 89 yrs. ____ mos. ____ ds.	If LESS than 1 day, ____ hrs. or ____ min.?	
OCCUPATION (a) Trade, profession, or particular kind of work:		
(b) General nature of industry, business, or establishment in which employed (or employer):		
BIRTHPLACE (City or town, State or foreign country): Ken		
PARENTS — NAME OF FATHER: Abraham McCormick		
BIRTHPLACE OF FATHER (City or town, State or foreign country): Ken		
MAIDEN NAME OF MOTHER: Dont know		
BIRTHPLACE OF MOTHER (City or town, State or foreign country):		

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs McCormick

(Address) Sedalia Mo

Filed Sept 5 1916 F. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 3rd (Month) (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from July 15, 1916, to Sept 2nd, 1916, that I last saw him alive on Sept 2nd, 1916, and that death occurred, on the date stated above, at Dont Know m.

The CAUSE OF DEATH* was as follows:

Interstitial nephritis

131 / 120

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory ________ (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Cord Bohling M. D.

Sept 3rd 1916 (Address) Sedalia Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Pleasant Hill | DATE OF BURIAL: 9-5 1916

UNDERTAKER: McLaughlin Bros | ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County ____________

Township ____________ Registration District No. ____________ File No. ____________
or
Village ____________ Primary Registration District No. ____________ Registered No. ____________
or
City ____________ (NO. ______ , ____________ St.; ______ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME ____________

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
SEX ______ COLOR OR RACE ______ SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) ______	DATE OF DEATH ______ (Month) ______ (Day), 191__ (Year)
DATE OF BIRTH ______ (Month) ______ (Day), 1____ (Year)	I HEREBY CERTIFY, that I attended deceased from ______, 191__, to ______, 191__, that I last saw h__ alive on ______, 191__, and that death occurred, on the date stated above, at ______ m.
AGE ______ yrs. ______ mos. ______ ds. If LESS than 1 day, ___ hrs. or ___ min.?	The CAUSE OF DEATH* was as follows: ______ (Duration) ______ yrs. ______ mos. ______ ds.
OCCUPATION (a) Trade, profession, or particular kind of work ______	Contributory (SECONDARY) ______ (Duration) ______ yrs. ______ mos. ______ ds.
(b) General nature of industry, business, or establishment in which employed (or employer) ______	(Signed) ______ M. D.
BIRTHPLACE (City or town, State or foreign country) ______	______, 191__ (Address) ______
PARENTS: NAME OF FATHER ______	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
BIRTHPLACE OF FATHER (City or town, State or foreign country) ______	LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
MAIDEN NAME OF MOTHER ______	At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
BIRTHPLACE OF MOTHER (City or town, State or foreign country) ______	Where was disease contracted if not at place of death? ______
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE	Former or usual residence ______
(Informant) ______	PLACE OF BURIAL OR REMOVAL ______ DATE OF BURIAL ______, 191__
(ADDRESS) ______	UNDERTAKER ______ ADDRESS ______
Filed ______, 191__, ______ REGISTRAR	