

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-017908

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

4675

STATE FILE NUMBER

FILED MAY 2 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 15 days	c. CITY OR TOWN Arcadia
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis - Little Rock Hospitals, Inc.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) P.O. Box 143

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First Bryant	Middle Lilburn	Last McCormack	Month April	Day 29	Year 1963
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3-14-1901	9. AGE (last birthday) 62	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telegrapher		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (City and state or country) Plattin, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME D.C. McCormack		13b. MOTHER'S MAIDEN NAME Hattie McMullin		14. NAME OF HUSBAND OR WIFE Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)		16. SOCIAL SECURITY NO. 9		17. INFORMANT Howard McCormack DeSoto, Mo.	

18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Carcinoma of the r.h. lung		6 mo
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) with bony metastasis	
	DUE TO (c) 163x	

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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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	COUNTY	STATE
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21. I attended the deceased from **April 14, 1963** to **April 28, 1963** and last saw ^{her} him alive on **4-28-63**
Death occurred at **10:55 P.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Handwritten Signature</i> (Degree or title) MD	22b. ADDRESS 1755 South Grand Blvd.	22c. DATE SIGNED 4/29/63
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23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 5-1-63	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) DeSoto, Missouri
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24. FUNERAL DIRECTOR Dietrich Funeral Home - De Soto, Mo.	ADDRESS	25. DATE REG. BY LOCAL REG. APR 29 1963	26. REGISTRAR'S SIGNATURE <i>Handwritten Signature</i> M.D.
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USE BLACK INK
OR
TYPEWRITER RIBBON

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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 _____

Lawrence

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.