FILED APR 26 1968

DEPARTMENT OF PUBLIC HEALTH AND WELFARE – MISSOURI DIVISION OF HEALTH

(PHYSICIAN OR CORONER)

CERTIFICATE OF DEATH

124

STATE FILE NUMBER 68 0018046

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3990

DO NOT WRITE ON THIS STUB

9.	1
10a.	86
10b.	
11.	0
12.	2
13.	4-12-3
14.	
15.	4
16.	
17.	
18.	0
19.	CREDITS
20.	

VS 300 Rev. 1/68

4.

5. 76

DECEASED

1. DECEASED—NAME (FIRST, MIDDLE, LAST): Rinna McCormack
2. SEX: Female
3. DATE OF DEATH (MONTH, DAY, YEAR): April 17, 1968
4. RACE (WHITE, NEGRO, AMERICAN INDIAN, ETC.) (SPECIFY): White
5a. AGE—LAST BIRTHDAY (YEARS): 86
5b. UNDER 1 YEAR (MOS., DAYS):
5c. UNDER 1 DAY (HOURS, MIN.):
6. DATE OF BIRTH (MONTH, DAY, YEAR): 4-10-1882
6a. COUNTY OF DEATH:
7a. CITY, TOWN, OR LOCATION OF DEATH: St. Louis
7c. INSIDE CITY LIMITS (SPECIFY YES OR NO): Yes
7d. HOSPITAL OR OTHER INSTITUTION—NAME (IF NOT IN EITHER, GIVE STREET AND NUMBER): St. Louis Chronic Hospital
8. STATE OF BIRTH (IF NOT IN U.S.A., NAME COUNTRY): Mo.
9. CITIZEN OF WHAT COUNTRY: U.S.A.
10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPECIFY): Widow
11. SURVIVING SPOUSE (IF WIFE, GIVE MAIDEN NAME):
12. SOCIAL SECURITY NUMBER: None
13a. USUAL OCCUPATION (GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE, EVEN IF RETIRED): Housewife
13b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE WHERE DECEASED LIVED. IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION.

6. 2157A

14a. RESIDENCE—STATE: Mo.
14b. COUNTY:
14c. CITY, TOWN, OR LOCATION: St. Louis
14d. INSIDE CITY LIMITS (SPECIFY YES OR NO): Yes
14e. STREET AND NUMBER: 5055 Gravois

PARENTS

15. FATHER—NAME (FIRST, MIDDLE, LAST): James Edwards
16. MOTHER—MAIDEN NAME (FIRST, MIDDLE, LAST): Josephine Wiggins

17a. INFORMANT—NAME: Chronic Records
17b. MAILING ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP): 5700 Arsenal St. Louis, Mo. 63139

CAUSE

PART I. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c))

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18 IMMEDIATE CAUSE (a)	Arteriosclerotic heart disease	3yrs
DUE TO, OR AS A CONSEQUENCE OF: (b)	Generalized Arteriosclerosis	4 yrs
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST: DUE TO, OR AS A CONSEQUENCE OF: (c)		

PART II. OTHER SIGNIFICANT CONDITIONS: CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (a)

19a. AUTOPSY (YES OR NO): No
19b. IF YES WERE FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH:

20a. ACCIDENT, SUICIDE, HOMICIDE, OR UNDETERMINED (SPECIFY):
20b. DATE OF INJURY (MONTH, DAY, YEAR):
20c. HOUR: M.
20d. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART II, ITEM 18):
20e. INJURY AT WORK (SPECIFY YES OR NO):
20f. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BLDG., ETC.) (SPECIFY):
20g. LOCATION (STREET OR R.F.D. NO., CITY OR TOWN, STATE):

CERTIFIER

21a. CERTIFICATION—PHYSICIAN: I ATTENDED THE DECEASED FROM (MONTH, DAY, YEAR): 9-4-1964
21b. TO (MONTH, DAY, YEAR): 4-17-1968
21c. AND LAST SAW HIM/HER ALIVE ON (MONTH, DAY, YEAR): 4-16-68
21d. I DID/DID NOT VIEW THE BODY AFTER DEATH: NO
21e. DEATH OCCURRED (HOUR): 4:15 PM
AT THE PLACE, ON THE DATE, AND, TO THE BEST OF MY KNOWLEDGE, DUE TO THE CAUSE(S) STATED.

22a. CERTIFICATION—MEDICAL EXAMINER OR CORONER: ON THE BASIS OF THE EXAMINATION OF THE BODY AND/OR THE INVESTIGATION, IN MY OPINION, DEATH OCCURRED ON THE DATE AND DUE TO THE CAUSE(S) STATED.
HOUR OF DEATH: M.
22b. THE DECEDENT WAS PRONOUNCED DEAD (MONTH, DAY, YEAR, HOUR): M.

23a. CERTIFIER—NAME (TYPE OR PRINT): B. J. McGinnis M.D.
23b. SIGNATURE: B. J. McGinnis M.D.
DEGREE OR TITLE:
23c. DATE SIGNED (MONTH, DAY, YEAR): 4-17-68
23d. MAILING ADDRESS—CERTIFIER: 4500 Arsenal (STREET OR R.F.D. NO.) St. Louis (CITY OR TOWN) Missouri (STATE) 63139 (ZIP)

BURIAL

24a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
24b. CEMETERY OR CREMATORY—NAME: Three Rivers Cemetry
24c. LOCATION (CITY OR TOWN, STATE): Route 2 Farmington, Mo.
24d. DATE (MONTH, DAY, YEAR): April 20, 1968
25a. FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP): Caldwell Funeral Home, Flat River, Missouri
25b. FUNERAL DIRECTOR—SIGNATURE: James T Creason
25c. REGISTRAR—SIGNATURE: Hoad Smith M.D.
26b. DATE RECEIVED BY LOCAL REGISTRAR: APR 18 1968

Type or print in PERMANENT BLACK INK. See handbook for instructions.

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 James L Cruson

Licensed Embalmer No. 5168

P. O. Address [illegible]

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.