

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **43231**

JAN 12 1953

BIRTH NO. _____		REG. DIST. NO. 316		PRIMARY REG. DIST. NO. 6075		Registrar's No. 404			
1. PLACE OF DEATH a. COUNTY St. Francois				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Ste. Genevieve					
b. CITY (If outside corporate limits, write RURAL and give township OR Rural St. Francois) TOWN near Farmington		c. LENGTH OF STAY (If in this place) 12 hrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Union		0950			
d. FULL NAME OF HOSPITAL OR INSTITUTION Osteopathic Hospital				d. STREET ADDRESS (If rural, give location) Farmington RFD 2					
3. NAME OF DECEASED (Type or Print) a. (First) Mary			b. (Middle) Amanda		c. (Last) Mc Cord		4. DATE OF DEATH (Month) (Day) (Year) Dec. 11, 1952		
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH Feb. 4, 1866			
9. AGE (In years last birthday) 86		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Care of Home		10b. KIND OF BUSINESS OR INDUSTRY own		11. BIRTHPLACE (City and State or Foreign Country) Ste. Genevieve, Mo.			
11. BIRTHPLACE (City and State or Foreign Country) Ste. Genevieve, Mo.		12. CITIZEN OF WHAT COUNTRY? U. S.		13a. FATHER'S NAME Waston McCord		13b. MOTHER'S MAIDEN NAME Martha Patterson			
13a. FATHER'S NAME Waston McCord		13b. MOTHER'S MAIDEN NAME Martha Patterson		14. NAME OF HUSBAND OR WIFE John P. McCord		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			
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. none		17. INFORMANT'S SIGNATURE OR NAME Carl McCormick, R.2, Farmington, Mo.		ADDRESS			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia				DUE TO (b) Myocarditis				DUE TO (c)	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (b) Myocarditis				DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.									
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from Dec 7 , 19 52 , to Dec 11 , 19 52 , that I last saw the deceased alive on Dec 11 , 19 52 , and that death occurred at 10:30 p.m., from the causes and on the date stated above.									
23a. SIGNATURE L. M. Stanfield (Degree or title)				23b. ADDRESS Farmington Mo		23c. DATE SIGNED 12/16/52			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 12-13-52		24c. NAME OF CEMETERY OR CREMATORY Little Vine		24d. LOCATION (City, town, or county) (State) R. F. 10. #2 Farmington Mo			
DATE REC'D BY LOCAL REG. Dec 16, 1952		REGISTRAR'S SIGNATURE E. R. Rudloff		25. FUNERAL DIRECTOR'S SIGNATURE E. J. Boyer		ADDRESS For Wesley Mo.			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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
Student Embalmer

Signed B. T. Boyer

Licensed Embalmer No. 3660

P. O. Address. Deer Lodge 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 this body is not embalmed, fact should be so stated above.