

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

Do not use this space.

SEP 30 1927

24990

**1. PLACE OF DEATH**

County *New Madrid*  
Township *Loma*  
City .....

Registration District No. *603-*  
Primary Registration District No. *5884*

File No. ....  
Registered No. ....  
St. .... Ward)

**2. FULL NAME**

*Laura Cornell*

(a) Residence. No. .... St. .... Ward. ....  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

4. COLOR OR RACE *Small white*  
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Divorced*

5A. MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Ed Cornell*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *1853-6-27*

7. AGE YEARS MONTHS DAYS  
*73 11 24*  
IF LESS than 1 day, ... hrs. ... min.

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work *House Keeping*  
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (CITY OR TOWN) .....

10. NAME OF FATHER *Ethan Allen*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....

12. MAIDEN NAME OF MOTHER *Patience Dye*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....

14. INFORMANT *Frank Boone*  
(Address) *Charleston, Mo.*

15. FILED *Aug 27 1927* *C. A. Blackman*  
REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Aug 21 1927*

17. I HEREBY CERTIFY, That I attended deceased from *about May 1, 1927* to *Aug 21, 1927*  
that I last saw *her* alive on *about July 1, 1927* and that death occurred, on the date stated above, at *7:30 p.m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Carcinoma of stomach*  
*463*

CONTRIBUTORY (SECONDARY) .....

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH, .....

DID AN OPERATION PRECEDE DEATH? *no* DATE OF *✓*

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Stomach*  
(Signed) *C. A. Blackman*, M. D.  
*Aug 21, 1927* (Address) *Panna, Mo*

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Panna, Mo.* DATE OF BURIAL *Aug 22 1927*

20. UNDERTAKER *C. A. Knight* ADDRESS *Panna, Mo*

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.

It should be stated EXACTLY. REVISIONS should be  
filed. Exact statement of OCCUPATION

USE OF "ATLANTA" in terms of  
it may be

1000  
1000  
1000

1000

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County New Madrid  
Township Como  
City (No. \_\_\_\_\_) \_\_\_\_\_

Registration District No. 605  
Primary Registration District No. 3-804

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Laura Cornell

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Div

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-27-1853

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
74 1 24

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY)

10. NAME OF FATHER \_\_\_\_\_

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY)

14. INFORMANT (Address) \_\_\_\_\_

15. FILED 1903 29 Blackburn REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 21 1927

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

, 19 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

PHYSICIANS should be consulted. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

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