

FILE APR 8 1940

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

12680
Do not use this space.

1. PLACE OF DEATH
 (a) County Lepus Registration District No. 1048
 (b) Township Clark Primary Registration District No. 6141 Registered No. 2
 (c) City..... (d) Street No. 5
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 654 Miss Darlene Cornelison
 (a) Residence, No. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 8 - 1939

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>0</u>	<u>3</u>	<u>26</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as lawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year).....
 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Adel Iowa

FATHER

13. NAME Wm. Cornelison
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Adel Iowa

MOTHER

15. MAIDEN NAME Myrtle Caeley
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Curie Mo.

17. INFORMANT (ADDRESS) Wm. Cornelison
 18. BURIAL, CREMATION, OR REMOVAL PLACE Big Creek DATE Mar. 5 1940
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Rev. Henry Higby
Curie Mo.
 20. FILED Mar 4 1940 Mrs. B.M. Willhite Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-4 1940

22. I HEREBY CERTIFY That I attended deceased from Northwest Medical 19.....
 I first saw him alive on 3-4-40 Death is said to have occurred on the date stated above, at Adel, Iowa m.
 The principal cause of death and related causes of importance were as follows:
Found dead in bed, apparently from natural causes
 Date of onset 11/11/39
 Other contributory causes of importance:
Intestinal Obstruction

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury..... 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify I.M. Reeds M. D.
 (Signed) 7815 (Address) Sumner Mo.

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

Registered Apprentice No....., working under my personal supervision.

Signed.....

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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12680

Registration District No. 1043-

Primary Registration District No. 6141

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Iowa
(b) City or town Bozard
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME

Lois D. Cornelison

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years
7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
3 26 _____ hr. _____ min.

9. Birthplace Plymouth, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Mar. 4, '40 (b) Mrs. S. M. Willett
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 4
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(c) Means of injury _____

23. Signature J. M. Reeder (M. D. or other) _____

Address Summersville Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

1940

S-12680