

FILED JUL 15 1940
399

Registration District No. _____

Primary Registration District No. **1002**

Registrar's No. **2515**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **9 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas Ckty**
(If outside city or town limits, write "RURAL")
(d) Street No. **R. R. 3 Independence**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME **James Cornelison** **1054**

8. (b) If veteran, **49418-7088** name was **James** 3. (c) Social Security No. **4000**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Minnie Prager** 6. (c) Age of husband or wife if alive **68** years

7. Birth date of deceased **Oct - 1868**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	70	8	13	hr. min.

9. Birthplace **Benton Co. Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer, railroad**

11. Industry or business _____

MOTHER FATHER

12. Name **Joseph Cornelison** 1
18. Birthplace **Edwardsville Ill.** (State or foreign country)
14. Maiden name **Mary Ann Carlach**
15. Birthplace **Edwardsville Ill.** (State or foreign country)

16. (a) Informant **Mrs. Arthur Schmitt**

(b) Address **223 East Cedar, Smith, Okla.**

17. (a) **Burial** (b) Date thereof **6-21-1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Springville**

18. (a) Signature of funeral director **W. C. Carson**

(b) Address **Independence, Mo.**

19. (a) **June 20, 1940** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **19th**
year **1940** hour **1:20 P.** minute _____ M.

21. I hereby certify that I attended the deceased from **December 13th 1939** to **June 19th, 1940**
that I last saw him alive on **June 19th, 1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic gangrenous cystitis; ascending pyelonephritis with embolic abscesses of kidneys**
Due to _____
Due to **1230**

Other conditions **Senility**
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy **See above**
Underline the cause to which death should be charged statistically.

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) (e) Means of injury **1**
23. Signature **P. De Maria MD** (M. D. or other)
Address **Supt. K.C. General Hospital, K.C. Mo.** Date signed _____

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

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.....

Floyd Carena

....., Registered Apprentice No.....

working under my personal supervision.

Signed *L. M. Kern*

Licensed Embalmer No. *3156*

P. O. Address *Indep 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, above space should be left blank.