1-10-39
-17-39
X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

1

State File No. 35430

REC'D NOV 19 1940

Registration District No. 347 Primary Registration District No. 3014 Registrar's No.

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Clinton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 617 S Carter
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 (Specify whether
In this community 53 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry
(c) City or town Clinton
(If outside city or town limits, write "RURAL")
(d) Street No. 617 S Carter
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

8. (a) PRINT FULL NAME William Nelson Cornick

8. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased 4 (Month) 17 (Day) 1862 (Year)

8. AGE: Years 78 Months 6 Days 25 If less than one day hr. min.

9. Birthplace Ripley (City, town, or county) Ohio (State or foreign country) 1

10. Usual occupation Contractor 9

11. Industry or business

MOTHER FATHER

12. Name Thomas Cornick

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

14. Maiden name

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

16. (a) Informant E. W. Cornick

(b) Address 3833 College Kansas City Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 14 40 (Month) (Day) (Year)

(c) Place: burial or cremation Englewood

18. (a) Signature of funeral director Frea E Wilkinson

(b) Address Clinton Mo

19. (a) (Date received local registrar) (b) Dag R. Hamilton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 12
year 1940 hour 5-15 minute P.M.

21. I hereby certify that I attended the deceased from 10/7, 1940 to 10/12, 1940
that I last saw h[illegible] alive on 10/12, 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Embolism	10 da
Antecedent cerebral thrombosis	5 da
Due to: Chronic Arteriolitis	8 yrs
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN

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

23. Signature E. C. Teelon M.D. (M. D. or other)
Address Clinton Mo Date signed 10/12/40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 11-40-1645
Date Filed 11-14-40

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 Kenneth Jackson

Licensed Embalmer No. 3954

P. O. Address Clinton Ind

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.

No. 2B
2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 35430

Registration District No. 347 Primary Registration District No. 3218

DEC 14 1940

Registrar's No.

1. PLACE OF DEATH:

(a) County Henry

(b) City or town Clinton (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 Wm Nelson Cornick

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

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 78 Months 2 Days 25 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER 12. Name

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

MOTHER 14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 12-11-40 (Date received local registrar) (b) Wm J. R. Hampton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 12

year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19, to , 19;

that I last saw h alive on , 19;

and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

PHYSICIAN

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Ed C Peelor (M. D. or other)

Address Clinton Mo Date signed

SUPPLEMENTARY