

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **39315**

Registration District No. **598**

Primary Registration District No. **4355-57**

Registrar's No. **82**

**1. PLACE OF DEATH:**  
(a) County **Morgan**  
(b) City or town **Moreau**  
(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 **7**

**3. (a) PRINT FULL NAME** **William Cornett**  
3. (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 **SARAH E. Sidleton**  
6. (c) Age of husband or wife if alive **1848** years  
7. Birth date of deceased **Mar 20 1848**  
(Month) (Day) (Year)

**8. AGE:**  
Years **92** Months **9** Days **0**  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Camber County Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business **Farmer**

**12. Name** **Stephen Cornett**

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

**14. Maiden name** **No Record**

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

**16. (a) Informant's own signature** **Rome Cornett**

(b) Address **Wersallen, Mo**

**17. (a) Burial** (b) Date thereof **Oct 22-40**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Union - Miller County**

**18. (a) Signature of funeral director** **W. F. Kidwell**

(b) Address **Wersallen, Mo**

**19. (a) 11/1/40** (b) **Will F. Berry, Jr.**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State **Missouri** (b) County **Morgan**  
(c) City or town **Rural**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **Moreau township**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month **Oct** day **20**  
year **1940** hour **4:** minute **30** P.M.

**21. I hereby certify that I attended the deceased from** \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him alive on **April 30**, 19**40**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Senility**  
**Scariness**  
Due to **old Age**  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) **162**

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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? \_\_\_\_\_

**23. Signature** **W. F. Kidwell** (M. D. or other)  
Address **Wersallen, Mo** Date signed \_\_\_\_\_  
(Specify type of place) (e) Means of injury \_\_\_\_\_

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.

RECEIVED

District Health Officer No. 7;

District File Number 12-40-1658

Date Filed 12-3-40

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.....

*Gene Barton*  
.....  
Licensed Embalmer No. 4021

P. O. Address. Versailles, 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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 39315-

Registration District No. 598

Primary Registration District No. 5797

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Morgan  
(b) City or town Morgan Twp  
(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 Missouri (b) County Morgan  
(c) City or town Rural  
(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 Cornett

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 1-20-1848  
(Month) (Day) (Year)

8. AGE: Years 92 Months 9 Days 0  
If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(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) 1-30-41 (b) Will F. Berry, Jr.  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Oct day 20  
year \_\_\_\_\_ 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 \_\_\_\_\_

Duration \_\_\_\_\_  
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? \_\_\_\_\_

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

23. Signature W. F. Berry, Jr. (M. D. or other) \_\_\_\_\_

Address St. Louis, Mo. Date signed \_\_\_\_\_

SUPPLEMENTARY

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

S-39315 1940