

X23155

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

Registration District No. 816

Primary Registration District No. 4492

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Chessee  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: N  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)

In this community 24 years  
years, months or days

3. (a) PRINT FULL NAME Ona Cornelia

3. (b) If veteran, name war

3. (c) Social Security No. ✓

4. Sex female 5. Color or race white

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

6. (b) Name of husband or wife Joe Harvey Cornelia

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased March 1 1873  
(Month) (Day) (Year)

8. AGE: Years 67 Months 10 Days 25  
If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Wm. M. Maerten

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

14. Maiden name Emma Sawberry

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

16. (a) Informant Harvey Cornelia

(b) Address Chessee Mo.

17. (a) BURIAL (b) Date thereof Jan 27 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Park Cem Chessee Mo.

18. (a) Signature of funeral director Bishophoff Hobbs

(b) Address Chessee Mo.

19. (a) 1/27/41 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott

(c) City or town Chessee  
(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.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 26  
year 1941 hour 12 minute 40 P. M.

21. I hereby certify that I attended the deceased from Jan. 25, 1941, to Jan. 26, 1941;  
that I last saw her alive on Jan. 26, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Unknown natural causes  
Duration 14 hrs.

Due to suspected meningitis resulting from influenza.

Due to influenza; non-ventilation.

Other conditions none  
(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? no  
(Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Wm. M. Heligene (M. D. or other) N.D.  
Address Chessee Mo. Date signed 1/26-41

RECEIVED

District Health Officer No. 2,

District File Number 241-139

Date Filed 2/3/41

**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 Mamie Bepling

Licensed Embalmer No. 3242

P. O. Address Chaffee 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 4499

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 816

Primary Registration District No. 4492

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

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

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Chaffee  
(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 \_\_\_\_\_  
In this community \_\_\_\_\_ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Ona Cornell

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

4. Sex F 5. Color or race W

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased Mar 1 1873  
(Month) (Day) (Year)

8. AGE: Years 67 Months 10 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 \_\_\_\_\_

MOTHER { 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) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 26  
year 1944 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 \_\_\_\_\_

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 Margel M. Delaney (M. D. or other)

Address Chaffee Mo Date signed \_\_\_\_\_

SUPPLEMENTARY

