S. No. 2
M—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 6405

Registration District No. FILED FEB 24 1944

Primary Registration District No. 1002

Registrar's No. 658

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: St. Joseph Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether years, months or days)
In this community 1 Year

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City Mo. 3
(If outside city or town limits, write "RURAL")

(d) Street No. 615 West 13th Street 8
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME ~~Miss~~ Ruth WOODWORKER.

3. (b) If veteran, name war None

3. (c) Social Security No. 500-05-0913

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife ##########

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

7. Birth date of deceased May (Month) 17 (Day) 1918 (Year)

8. AGE: Years 25 Months 8 Days 21 If less than one day hr. min.

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

10. Usual occupation North American Avia

11. Industry or business

FATHER
12. Name Wm. Cornelison
13. Birthplace unk (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name May
15. Birthplace unk (City, town, or county) 9 (State or foreign country)

16. (a) Informant Mr. Holtzclaw
(b) Address Independence Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/9/44 (Month) (Day) (Year)

(c) Place: burial or cremation Branson Missouri

18. (a) Signature of funeral director Mellody-McGilley
(b) Address Kansas City Mo.

19. (a) 2-8-44 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 8th year 1944 hour 10:10 minute A. M.

21. I hereby certify that I attended the deceased from Jan 21 1944, to Feb 8 1944 that I last saw her alive on Feb 8 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory Failure under Ether anesthesia

Due to Thymic Enlargement

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy 64

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature William M Korth (M. D. or other) M.D.

Address 612 Professional Bldg Date signed 2/8/44

(Licensed Embalmer's Statement on Reverse Side)

Dr. Korth
Prof. Blvd.

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. 2999

P. O. Address..... KC

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.