S. No. 2
M—5-43
. 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

31411

FILED SEP 22 1945

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 317 Primary Registration District No. 3069 Registrar's No. 2219

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
St. Mary's Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Weeks (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis 96

(c) City or town Chesterfield (Rural) 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME John L. Corley

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife Beulah Corley

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

7. Birth date of deceased Sept. (Month) 25, (Day) 1876 (Year)

8. AGE:

Years	Months	Days	If less than one day
68	11	18	hr. min.

9. Birthplace Dont Know (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation Attorney

11. Industry or business

FATHER
12. Name Henry Corley
13. Birthplace (City, town, or county) Ireland 4 (State or foreign country)

MOTHER
14. Maiden name Rose Ellen Mudd
15. Birthplace (City, town, or county) Kentucky 1 (State or foreign country)

16. (a) Informant Mrs. Beulah Corley
(b) Address Chesterfield Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-45 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Arthur J. Donnelly
(b) Address 3840 Lindell Blvd

19. (a) 9-15-45 (Date received local registrar) (b) C. G. McGavin M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 13
year 1845 hour 5 minute 15P. M.

21. I hereby certify that I attended the deceased from July 8, 1945 to Sept 13, 1945
that I last saw him alive on Sept 12, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Ventricular Fibrillation	X 1
Due to Sclerotic Heart Disease Chronic	XX
Due to Arterio Sclerosis Hert 93	X 1

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 Guy Simpson (M. D. or other) M.D.
Address 3833 Washington Date signed 9/14/45

(Licensed Embalmer's Statement on Reverse Side)

3833
West
11

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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lindell

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.