U. S. No. 2
10M—5-43
Rev. 5-17-39
No. I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 25 1947

Registration District No. 1

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4020.

30257

State File No.

Registrar's No.

1. PLACE OF DEATH:

(a) County: Audrain

(b) City or town: Martinsburg Mo.
(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 years, months or days)

In this community: 20 Years.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Audrain

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

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

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

If yes, name country

3. (a) PRINT FULL NAME: Stephen Nicholas Corder.

3. (b) If veteran, name war

3. (c) Social Security No. 486-16-6997

4. Sex: M

5. Color or race: W

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

6. (b) Name of husband or wife: Buela Corder

6. (c) Age of husband or wife if alive: 58 years

7. Birth date of deceased: Nov - 18 - 1873 (Month) (Day) (Year)

8. AGE: Years 73 | Months 9 | Days 13 | If less than one day hr. min.

9. Birthplace: Callaway Co Mo. (City, town, or county) (State or foreign country)

10. Usual occupation: Retired Farmer

11. Industry or business: Farming.

MOTHER FATHER

12. Name: James B Corder

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

14. Maiden name: Sarah Ann Matheney.

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

16. (a) Informant: Mrs Buela Corder.

(b) Address: Martinsburg Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9/2/47. (Month) (Day) (Year)

(c) Place: burial or cremation: Martinsburg Mo.

18. (a) Signature of funeral director: W.B. Wells

(b) Address: Wellsville Mo.

19. (a) Sept. 15. 47 (Date received local registrar) (b) Mrs. Joe Carter. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 31 year 1947 hour 7 minute 5 a.m.

21. I hereby certify that I attended the deceased from Aug 27, 1947, to Aug 31, 1947, that I last saw him alive on Aug 31, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death: apoplexy — Duration: 3 Day

Due to: Hypertension — 10 Years

Due to:

Other conditions (Include pregnancy within 3 months of death):

Major findings: Of operations: 83 A

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: 2

23. Signature: Willis H. Wells (M. D. or other) DO.

Address: Wellsville Date signed: 9/1/47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 9.47.1305
Date Filed SEP 24 1947

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~~ Self

....., Registered Apprentice No. ....,

working under my personal supervision.

Signed N B Wells

Licensed Embalmer No. 1588

P. O. Address Willsville, 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.