

S. No. 2  
M-8-43  
5-17-39  
X 317823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **9388**

FILED MAR 25 1948

Registration District No. **209**

Primary Registration District No. **3043**

Registrar's No. **92**

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

**1. PLACE OF DEATH:**

(a) County Marion

(b) City or town Hannibal

(c) Name of hospital or institution: Revering Hosp. days 0  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 6 days  
(If not in hospital or institution, write street number or location)

In this community Life  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Pike **82**

(c) City or town Frankford **0**  
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? No (Yes or No) **1**  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** EDWARD LAWTON CORWINE

3. (b) If veteran, name war -

3. (c) Social Security No. -

4. Sex W.H.I.T.E. 5. Color or race M.A.L.E.

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

6. (b) Name of husband or wife FANNIE CORWINE

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

7. Birth date of deceased JAN 10 1890  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>78</u>	<u>2</u>	<u>-</u>	hr. _____ min. _____

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

10. Usual occupation Lawyer

**MOTHER FATHER**

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

12. Name JOHN BROOKS CORWINE

13. Birthplace MAYSVILLE KENTUCKY  
(City, town, or county) (State or foreign country)

14. Maiden name MATTIE M. GOOD

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

16. (a) Informant Mrs. Arlie Lake

(b) Address New London, Mo

17. (a) Burial (b) Date thereof MAR 12 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Frankford, Mo

18. (a) Signature of funeral director Fielder Estlow

(b) Address Frankford, Mo

19. (a) 3-12-48 (b) Dr. E. M. Luete  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 3 day 10  
year 48 hour 1 minute 30 P.M.

21. I hereby certify that I attended the deceased from 3-1  
\_\_\_\_\_, 1948, to 3-10, 1948

that I last saw him alive on 3-10, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Hypertension  
(Include pregnancy within 6 months of death)

**PHYSICIAN**

Major findings:  
Of operations none

Of autopsy none

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 John A. Rank (M. D. or other) \_\_\_\_\_

Address 106 1/2 S. 1st St. Hannibal, Mo Date signed 3/12/48

**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..... *Joe Fields Megowan* .....

Licensed Embalmer No. *4092* .....

P. O. Address *Frankford, 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.**