

FILED SEP 19 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31138**

BIRTH NO. _____ REG. DIST. NO. **274** PRIMARY REG. DIST. NO. **3056** Registrar's No. **213**

883
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY RANDOLPH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY MONROE	
b. CITY OR TOWN Moberly	c. LENGTH OF STAY (in this place township) 5 WKS	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN WOODLAWN 0690	
d. FULL NAME OF HOSPITAL OR INSTITUTION Woodland Hosp		d. STREET ADDRESS (If rural, give location) 1	

3. NAME OF DECEASED (Type or Print) a. (First) Ada	b. (Middle)	c. (Last) Cornick	4. DATE OF DEATH (Month) (Day) (Year) 9-10-1951
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5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 4-3-1880	9. AGE (In years last birthday) 71 IF UNDER 1 YEAR Months 5 Days 7 IF UNDER 6 HRS. Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MO	12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Joe Boulware	13b. MOTHER'S MAIDEN NAME ANN Snidow	14. NAME OF HUSBAND OR WIFE Eldridge Cornick
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. ✓	17. INFORMANT'S SIGNATURE OR NAME Eldridge Cornick ADDRESS Woodlawn, Mo
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18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 months
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Nephritis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis DUE TO (c) Calcified fibroid tumor		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 446X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Aug 10, 1951**, to **Sept 10, 1951**, that I last saw the deceased alive on **Sept 10, 1951**, and that death occurred at **6:30 a. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) David H. Lewis, M.D.	23b. ADDRESS Moberly, Mo.	23c. DATE SIGNED Sept 10, 1951
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 9-12-1951	24c. NAME OF CEMETERY OR CREMATORY MADISON	24d. LOCATION (City, town, or county) (State) MADISON MO
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DATE REC'D BY LOCAL REG. 9-12-51	REGISTRAR'S SIGNATURE Leah Ballance	25. FUNERAL DIRECTOR'S SIGNATURE Joe Hopper ADDRESS Funeral Home	ADDRESS Clarence
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SEP 28 1951

SEP 17 1951

Date Received:
DISTRICT HEALTH OFFICE #2
District File Number 9-51-164
Date Filed:

SEP 17 1951

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....

Louis E. Foye

Signed.....
Student Embalmer

Licensed Embalmer No. 426

P. O. Address Channah N.

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.