

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **17946**

FILED JUN 20 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **53** PRIMARY REG. DIST. NO. **3010** Registrar's No. **259**

1. PLACE OF DEATH a. COUNTY <b>CAPE GIRARDEAU</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>SCOTT</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>CAPE GIRARDEAU</b>	c. LENGTH OF STAY (in this place) <b>1 DAY</b>	c. CITY OR TOWN <b>CHAFFEE</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>CAPE OSTEOPATHIC HOSP</b>		STREET ADDRESS (If rural, give location) <b>431 WRIGHT AVE 1001</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>CHARLES</b> b. (Middle) <b>EVERETT</b> c. (Last) <b>CORBIN</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>JUNE 4, 1955</b>
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>MARCH 24, 1876</b>	9. AGE (In years last birthday) <b>79</b> IF UNDER 1 YEAR Months <b>2</b> Days <b>20</b> IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LUMBERMAN</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>LUMBER</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>GREEN COUNTY, INDIANA</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>FRANK CORBIN</b>	13b. MOTHER'S MAIDEN NAME <b>NANCY CARR</b>	14. NAME OF HUSBAND OR WIFE <b>MILDRED GERTRUDE</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>490-10-8243</b>	17. INFORMANT'S SIGNATURE OR NAME <b>MR. CLAUDE CORBIN</b>	ADDRESS <b>UNION, MO.</b>
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>MYOCARDIAL FAILURE</b>		<b>6 HRS</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>AURICULAR FIBRILLATION</b>		<b>6 HRS</b>
DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>HYPERTROPHIED PROSTATITIS</b>		<b>1 1/2 HRS</b>	
<b>ABDOMINAL TUMOR (UNDETERMINED)</b>		<b>1 1/2 HRS</b>	

19a. DATE OF OPERATION <b>NONE</b>	19b. MAJOR FINDINGS OF OPERATION <b>NONE</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE NATURAL (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NONE</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>NONE</b>	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 **FEB**, 1954, to **JUNE**, 1955, that I last saw the deceased alive on **6-13**, 1955, and that death occurred at **10:12 Am.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>H. J. Mosebach, D.O.</b>	23b. ADDRESS <b>Chaffee, Mo.</b>	23c. DATE SIGNED <b>6-15-55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>JUNE 18, 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK</b>	24d. LOCATION (City, town, or county) (State) <b>CAPE GIRARDEAU, MISSOURI</b>
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DATE REC'D BY LOCAL REG. <b>6-17-55</b>	REGISTRAR'S SIGNATURE <b>L. C. Summers</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Displinghoff Funeral Home</b>	ADDRESS <b>Chaffee, Mo</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUN 21 1955

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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 ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Jack J. Burnett*

Licensed Embalmer No. *44*

P. O. Address *Chaffee,*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.