

Health,
, & Welfare
S. Public
th Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022193

STATE FILE NUMBER

FILED JUN 26 1959

Registration District No. 212

Primary Registration District No. 3044

Registrar's No. 14

S. 300
v. 1-57

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY MILLER | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Miller | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ELDON | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN ELDON | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION | Length of stay in 1b 15 minutes | d. STREET ADDRESS 666 | (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

| | | | | | |
|--|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last Clifford-William-Cornett | | | 4. DATE OF DEATH Month Day Year June-18-1959 | | |
|--|--|--|---|--|--|

| | | | | | | |
|-----------------------|----------------------------------|---|--|--|--------------------------------|-------------------------------|
| 5. SEX MALE | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11 April-1916 | 9. AGE (In years last birthday) 43 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS Hours Min. |
|-----------------------|----------------------------------|---|--|--|--------------------------------|-------------------------------|

| | | | |
|---|---|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic- | 10b. KIND OF BUSINESS OR INDUSTRY Auto- | 11. BIRTHPLACE (City and state or country) Morgan-Co-Mo | 12. CITIZEN OF WHAT COUNTRY? U.S.A |
|---|---|---|--|

| | | |
|---|---|---|
| 13a. FATHER'S NAME Willie-Cornett | 13b. MOTHER'S MAIDEN NAME Aurina-Cooper | 14. NAME OF HUSBAND OR WIFE Lois-Rivers-Cornett |
|---|---|---|

| | | | |
|--|-------------------------|---------------------------------------|----------------------------|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WWII | 16. SOCIAL SECURITY NO. | 17. INFORMANT Lois-Cornett- | Address ELDON-MO |
|--|-------------------------|---------------------------------------|----------------------------|

| | | | |
|---|------------------------------------|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory-Failure | | | INTERVAL BETWEEN ONSET AND DEATH 60 sec 10 MIN |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Rupture-of-Arta- | | |
| | DUE TO (c) BULLET-WOUND | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 981X | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2 |

| | |
|--|--|
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Gun-Fired-By-Floyd-Felthrop |
|--|--|

| | | | | | |
|---|--|---|---|--------------------------|--------------------|
| 20c. TIME OF INJURY Hour Month, Day, Year About 9:45 p.m. June-18-1959 | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) RESA-TAVERN- | 20f. CITY, TOWN, OR LOCATION ELDON- | COUNTY MILLER- | STATE MO |
|---|--|---|---|--------------------------|--------------------|

| |
|--|
| 21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at About-9:45 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated. |
|--|

| | | |
|---|-------------------------------------|---------------------------------------|
| 22a. SIGNATURE (Degree or title) Herman V. Abbott, Sheriff. 3 | 22b. ADDRESS Tuscumbia-Mo | 22c. DATE SIGNED 19 June-59 |
|---|-------------------------------------|---------------------------------------|

| | | | |
|---|----------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial- | 23b. DATE 21 June-1959 | 23c. NAME OF CEMETERY OR CREMATORY Union- | 23d. LOCATION (City, town, or county) (State) Morgan-Co-Mo |
|---|----------------------------------|---|--|

| | | | |
|--|----------------------------|--|--|
| 24. FUNERAL DIRECTOR Keith M. Kaye | ADDRESS ELDON-MO | 25. DATE RECD. BY LOCAL REG. June 20, 59 | 26. REGISTRAR'S SIGNATURE Alveretta Walt |
|--|----------------------------|--|--|

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

192
0

6961 9 6 1959

6961 6 2 1959

Health Department
Miller County

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 *Keith McKays*

Licensed Embalmer No. *3998*
P. O. Address *Eldon 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.