

**MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-040164**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 042

Primary Registration District No. 1000

Registrar's No. 1194

STATE FILE NUMBER

AMENDED

**FILED DEC 4 1961**

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>	Length of stay in 1b <b>1 day</b>	c. CITY OR TOWN <b>Faucett</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>713 S. 7th St.</b>		d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>MILBERT CORNETT</b>			4. DATE OF DEATH Month <b>November</b> Day <b>22</b> Year <b>1961</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/1/1894</b>	9. AGE (last birthday) <b>67</b>	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired elevator operator</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Light &amp; Power Co.</b>	11. BIRTHPLACE (City and state or country) <b>Platte County, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Tom Cornett</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Duck</b>	14. NAME OF HUSBAND OR WIFE <b>Ada</b>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes W.W.#1</b>	16. SOCIAL SECURITY NO. <b>W.W.#1</b>	17. INFORMANT <b>Mrs. Ada Cornett, Faucett, Mo.</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Unattended Death-Natural Causes</b> DUE TO (b) <b>Investigated by the City Health Department</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
		20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from \_\_\_\_\_, to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_.  
Death occurred at **10:45 a.** \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Robert W. Kieber, M.D. Health Officer</b>	22b. ADDRESS <b>St Joseph, Mo</b>	22c. DATE SIGNED <b>11/24-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>11/25/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Faucett Cemetery</b>
		23d. LOCATION (City, town, or county) (State) <b>Faucett, Missouri</b>
24. FUNERAL DIRECTOR <b>Heaton-Bowman</b>	ADDRESS <b>St. Joseph, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Nov. 27, 1961</b>
		26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Standell</b>

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF **Rw. Kieber, M.D.**

DEC 5 1961

**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 William Gaudin

Licensed Embalmer No. 4525

P. O. Address St Joseph

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.