

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

10784-61-042287 STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. \_\_\_\_\_

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

FILED NOV 28 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri</b>		c. CITY OR TOWN <b>Centralia</b>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Cardinal Glennon Memorial</b>		d. STREET ADDRESS (If outside, give location) <b>28 Arline Dr.</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Scott</b> Middle <b>Hospital</b> Last <b>Cornell</b>			4. DATE OF DEATH Month <b>11</b> Day <b>19</b> Year <b>61</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-14-57</b>	9. AGE (last birthday) <b>4 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Illinois</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>William B. Cornell</b>	13b. MOTHER'S MAIDEN NAME <b>Mariellen Moss</b>	14. NAME OF HUSBAND OR WIFE -----
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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)	16. SOCIAL SECURITY NO.	17. INFORMANT <b>William B. Cornell</b>	Address <b>28 Arline Dr. Centralia, Ill.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracardiac Tumor</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	DUE TO (c) <b>151X</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Pleural Effusion; Pericardial Effusion</b>	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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <b>None</b>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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
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21. I attended the deceased from November 17, 1961 to November 19, 1961 and last saw <sup>her</sup>him alive on November 19, 1961  
Death occurred at 4:15 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>James P. King M.D.</b>	(Degree or title)	22b. ADDRESS <b>1465 S. Grand Avenue</b>	22c. DATE SIGNED <b>11/20/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11-22-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Lawn Memorial Park, Indianapolis</b>	23d. LOCATION (City, town, or county) (State) <b>Indiana</b>
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24. FUNERAL DIRECTOR <b>IRA HARNIER CENTRALIA</b>	ADDRESS	25. DATE REC'D. BY LOCAL REG. <b>NOV 20 1961</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>
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Specified - maligant

MEDICAL CERTIFICATION

DOCUMENT

**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

*John J. Kausly III*

Licensed Embalmer No. 5039

P. O. Address E. St. Louis

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.