MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH
County Barry Registration District No. 0555 File No. 3 7734
Township Roaring River #1 Primary Registration District No. 8 Registered No.
City (No. St. Ward)

2. FULL NAME William A. Cornell

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Francis Cornell

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-8-1852

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	81		22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Ill

PARENTS
10. NAME OF FATHER Charles C. Cornell
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Dont Know
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Dont Know

14. INFORMANT Clark R Cornell
(Address) Seligman, Mo. R.2

15. FILED 3-14-1934 Emma Swearingen REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-2 1934

17. I HEREBY CERTIFY, That I attended deceased from 5/8 1933, to 3/2 1934, that I last saw h... alive on 2/2 1934, and that death occurred, on the date stated above, at 9:30 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral Stenosis
Cardiac Decompensation
1 2 0
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Cardiac Decompensation
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) [illegible] M. D
, 19 (Address) Cassville, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Munsey Cemetary
DATE OF BURIAL 3-4 1934
20. UNDERTAKER W. D. Koon
ADDRESS Cassville Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

[illegible]