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

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.

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

PLACE OF DEATH

County: Knox

Township: Lyon
or
Village:
or
City: (NO. St.; Ward)

Registration District No. 443 File No. 138020

Primary Registration District No. 5601a Registered No. 19

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Joseph A. Corbin

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: May (Month) 6 (Day), 1855 (Year)

AGE: 61 yrs. 6 mos. 6 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Kentucky

PARENTS
NAME OF FATHER: John H. Corbin
BIRTHPLACE OF FATHER (City or town, State or foreign country): Kent
MAIDEN NAME OF MOTHER: W K Ashurst
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Kent

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leonard Corbin

(ADDRESS) Hurdland Mo

Filed Nov 14 1916. B. H. Henry REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: 11 (Month) 13 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov. 8, 1916, to Nov. 13, 1916, that I last saw him alive on Nov. 13, 1916, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

12-4-1113 (Duration) about 2 yrs. ___ mos. ___ ds.

Contributory (SECONDARY) ___ (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) B. H. Henry M. D.

Nov. 14 1916 (Address) Hurdland

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Sirian G. O. O. F.

DATE OF BURIAL: 11-15, 1916

UNDERTAKER: F. W. Maynders

ADDRESS: Hurdland Mo

PLACE OF DEATH

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

County.....

Township ..... Registration District No..... File No.....

or

Village..... Primary Registration District No..... Registered No.....

or

City .....(NO..... .....St.:.....Ward)

[If death occurred hospital or institu give its NAME in of street and numbe

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... *1*.....
(Month) (Day) (Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., *19.*
(Month) (Day) (Y

I HEREBY CERTIFY, that I attended deceased

....., 191....., to....., 191

that I last saw h.....alive on....., 191

and that death occurred, on the date stated above, at.....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....

(Signed).....

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	.....
UNDERTAKER	ADDRESS