

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

Do not use this space.

5744

1. PLACE OF DEATH

County Randolph Registration District No. 735 File No. 40
 Township Moberly Primary Registration District No. 3834 Registered No. 1st
 City Moberly (No. McCormick Hospital St. 1st Ward)

2. FULL NAME

Ethel Alberta Corey
 (a) Residence. No. _____ St. _____ Ward. Bynumville, Mo.
 (Usual place of abode) (If no resident 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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 19, 1918

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
9 6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.
 (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) Bynumville, Mo.

10. NAME OF FATHER James Thomas Corey

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Nellie Brewer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.

14. INFORMANT (Address) Mrs. J. T. Corey Bynumville, Mo.

15. FILED 2/25 1927 Thos. Fleming REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 25 - 1927

17. I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1927 to Feb. 25, 1927 that I last saw her alive on Feb. 25, 1927 and that death occurred, on the date stated above, at 8:45 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Burns, multiple over body. Accidental explosion of Gasoline Lamp.
 (duration) yrs. mos. 25 hrs.

CONTRIBUTORY (SECONDARY) Unknown
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?

19. DID AN OPERATION PRECEDE DEATH? DATE OF

20. WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) F. L. McCormick, M. D.
2-25, 1927 (Address) Moberly, Mo.

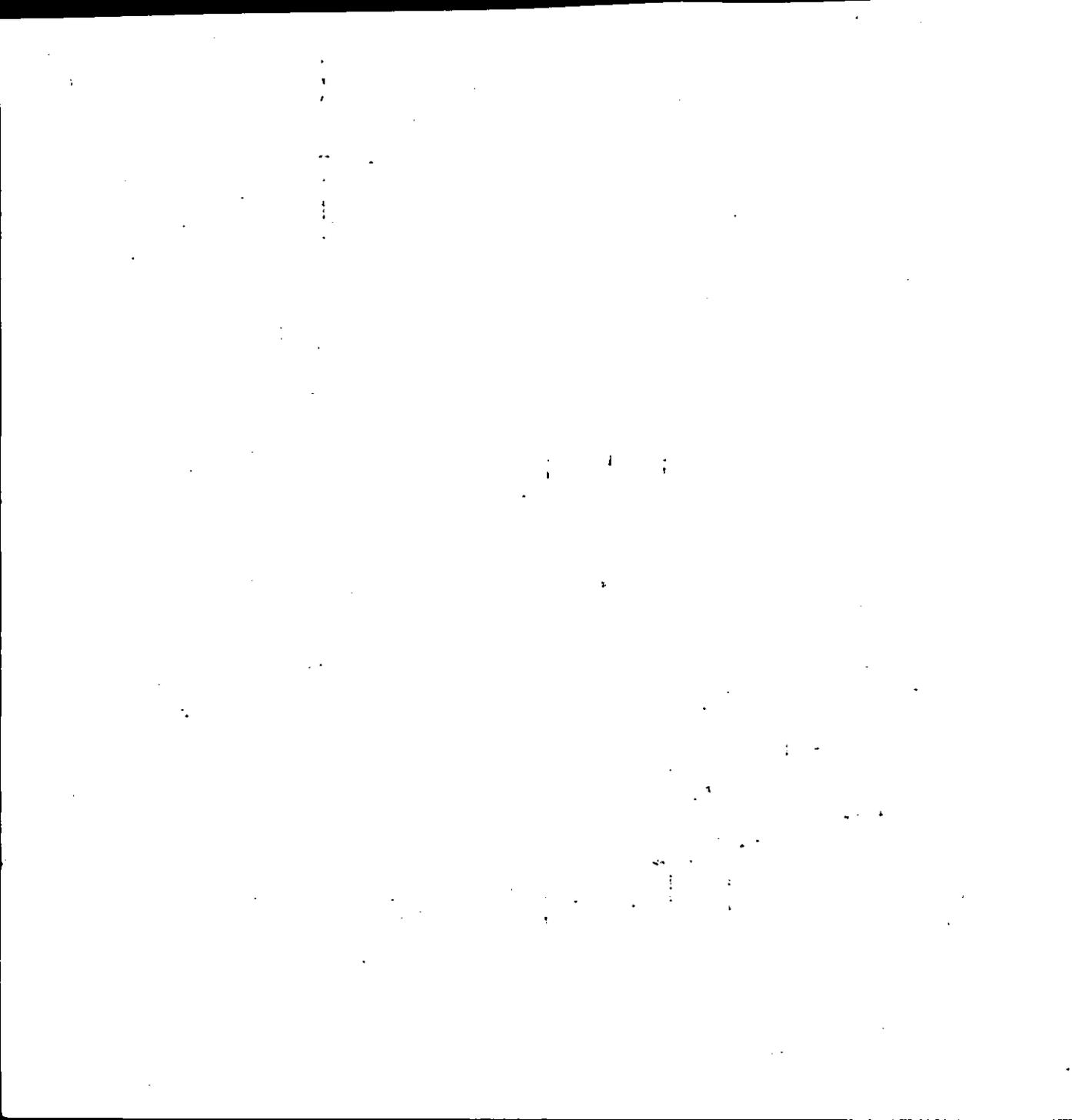
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Bynumville Mo 2-27 - 1927

20. UNDERTAKER ADDRESS
Mahan and Son Moberly Mo

PARENTS

28 1927



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION RELAYED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Randolph Registration District No. 725 File No. _____
 Township _____ Primary Registration District No. 3034 Registered No. 40
 City Moberly St. _____ Word) _____

2. FULL NAME

(a) Residence No. _____ St. _____ Word _____
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX D 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
- (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)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY)

14.

INFORMANT (Address) _____

15.

FILED 2/25, 1927 Thos. S. Fleming
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 25 1927

17. I HEREBY CERTIFY That I attended deceased from _____, 19____ to _____, 19____ (that I last saw him alive on _____, 19____, and that death occurred, on the date stated above at _____ in _____.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Bumps multiple over head accidental explosion of gasoline lamp
 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Unknown Have died max _____
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) _____, M. D.
 _____, 19 (Address)

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

S-5744