

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

Do not use this space.

30133

**1. PLACE OF DEATH**

County Greene  
Township North  
City North

Registration District No. 330  
Primary Registration District No. 3017

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Amamay Corbin

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 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 L

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 23 - 1910

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
16 - 16

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work House Keeper  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Greene Co., MO  
(STATE OR COUNTRY)

10. NAME OF FATHER Wm. Corbin

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

12. MAIDEN NAME OF MOTHER Lena Bryant

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

14. INFORMANT J. C. Bryant  
(Address) North R. 5

15. FILED Oct 10 1927 E. A. Weir  
19\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct - 9 19 27

17. I HEREBY CERTIFY That I attended deceased from Oct 7, 1927, to Oct 9, 1927, that I last saw him alive on Oct 9, 1927, and that death occurred, on the date stated above, at 9:30 P.M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS**

Acute Anterior Poliomyelitis  
16 (duration) yrs. mos. 3 da.

CONTRIBUTORY None Known  
(SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED /

IF NOT AT PLACE OF DEATH \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical  
(Signed) Dr. Roots, M. D.

10/10, 1927 (Address) Greentown 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

old folks cemetery Oct 27  
20. UNDERTAKER Dipson ADDRESS Greentown

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.

