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

Do not use this space.

File No. 23971

Registered No.

1. PLACE OF DEATH

County Jackson — Registration District No. 393

Township Research Hospital — Primary Registration District No.

City Kansas City (No. Research Hospital St. Ward)

2. FULL NAME Thomas Acy Corn

(a) Residence. No. 1136 S. Dodgeon St., Ward. Independence, Mo.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 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	single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) October 11, 1899

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	28	9	7	

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Buckner
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Robert William Corn

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

12. MAIDEN NAME OF MOTHER Jennie Stewart

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

14. INFORMANT Robert William Corn
(Address) Indep, Mo

15. FILED 7/20, 1928 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 18 — 1928

17. I HEREBY CERTIFY, That I attended deceased from April 8 — 1927, to 18 July 1928, that I last saw him alive on 18 July 1928, and that death occurred, on the date stated above, at 5 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Heart Failure.
Compression superior ~~Venacava~~
Venocava.
(duration) yrs. 1 mos. ds.

CONTRIBUTORY (SECONDARY) Mediastinal Tumor
Thymoma.
(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? Yes.

WHAT TEST CONFIRMED DIAGNOSIS? Vry. Clinical Autopsy

(Signed) Donald R Black, M.D.

7-19, 1928 (Address) 743 Lathrop Bldg. K.C. 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
Oakland Cemetery	7/19/28
20. UNDERTAKER	**ADDRESS**
Vernon M. Reppert	Buckner

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County ..... Registration District No. 399 File No. .....

Township ..... Primary Registration District No. 1002 Registered No. 3098

City K. City (No. ....., ... St. ..... Ward)

2. FULL NAME Thomas Acy Corn

(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 M

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) D

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 7/20, 1928 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 18 1928

17. I HEREBY CERTIFY, That I attended deceased from 8 April, 1927, to 18 July, 1928 that I last saw him alive on 18 July, 1928, and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Heart Failure secondary to Medical Pressure from Mediastinal tumor.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Mediastinal tumor Thymoma Malignant

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy Yes

(Signed) Donald R Black, M. D

, 19 (Address) 743 Lathrop Bldg.

*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 19

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY

N. B.—Every item ... be stated EXACTLY. PHYSIC... CAUSE OF DEATH ... it m... exact statement of OCCUPATION ... tant.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-23971