

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

Do not use this space.

18464

1. PLACE OF DEATH
 County Johnson Registration District No. 429
 Township Washington Primary Registration District No. 4253
 City Knob Noster Mo St. _____ Ward _____

2. FULL NAME Alan V. Cornelius
 (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 male
 4. COLOR OR RACE white
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb-15-1928
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
3 2 18
 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) Sweet Springs, Mo
 (STATE OR COUNTRY)
 10. NAME OF FATHER Sam Cornelius
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Maurine Mo
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Wada Graves
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Johnson Co Mo
 (STATE OR COUNTRY)

14. INFORMANT Sam Cornelius
 (Address) Knob Noster Mo
 15. FILED 5/15 1931 J. A. Koch
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 3 1931
 17. I HEREBY CERTIFY, That I attended deceased from May 1 1931 to May 3 1931 that I last saw him alive on May 3 1931, and that death occurred, on the date stated above, at 10:45 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
108
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 108
 (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? no
 WHAT TEST CONFIRMED DIAGNOSIS? clinical
 (Signed) J. E. Porter, M. D.
3/4 1931 (Address) Knob Noster 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 Ctr. Bur DATE OF BURIAL 5/7 1931
 20. UNDERTAKER Ch. Sauter ADDRESS K. R.

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.

