

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

Do not use this space.

SEP 16 1935

27585

1. PLACE OF DEATH

County.....
Township.....
City St. Louis

Registration District No. **791**

Primary Registration District No. **1003**

File No.
Registered No. **6621**
St. Ward)

2. FULL NAME

Mary Corner

(a) Residence, No. Christian Hospital St. Ward. NR
(Usual place of abode) 6522 Bartmes Ave (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 7 4. COLOR OR RACE Wh 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) Aug 2, 1935
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MOTHER FATHER
13. NAME Frank Corner

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

15. MAIDEN NAME Jessie Shields

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT Frank Corner
(ADDRESS) 6522 Bartmes

18. BURIAL, CREMATION, OR REMOVAL PLACE Bethel Cmty DATE 8/5/35

19. UNDERTAKER Louis H. Bode
(ADDRESS) Kirkwood, Mo.

20. FILED AUG - 3 1935 19 JH Bredeck
Registrar.

MEDICAL CERTIFICATE OF DEATH

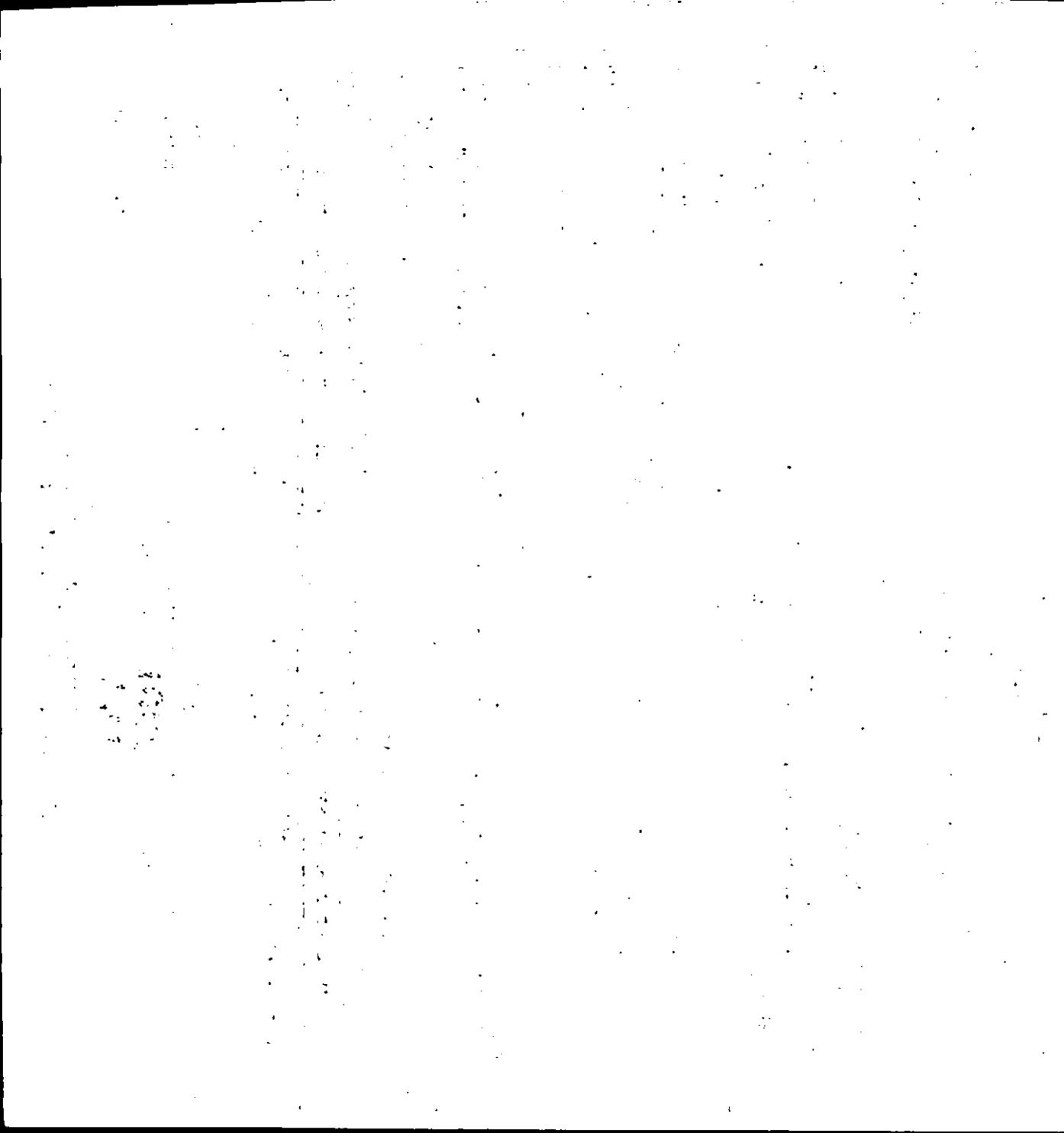
21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8/2/35
22. I HEREBY CERTIFY, That I attended deceased from 8/2, 1935, to 8/2, 1935.
I last saw him alive on 8/2/35 19... Death is said to have occurred on the date stated above, at 7:35 P m.
The principal cause of death and related causes of importance were as follows:

Still born
Date of onset
Other contributory causes of importance:
Patent Foramen Ovale

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury..... 19...
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
If so, specify Patent Foramen Ovale
(Signed) Carl B. Emstorf, M. D.
(Address) 3919 W. Florissant



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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City..... (No. Christian Hosp)..... St. Ward)

File No. 6621
Registered No.
St. Ward)

2. FULL NAME

Mary Corner
(a) Residence, No. 6522 Bertner 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

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-2-1935

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

22. I HEREBY CERTIFY, That I attended deceased from 19....., to..... 19.....
I first saw h..... alive on..... 19..... Death is said

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 2, 1935

to have occurred on the date stated above, at 12:40 P

7. AGE YEARS MONTHS DAYS If LESS than day, or min.

The principal cause of death and related causes of importance were as follows:

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.

Premature
Date of onset

Other contributory causes of importance: 1570

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Name of operation..... Date of.....

FATHER 13. NAME

What test confirmed diagnosis?..... Was there an autopsy?.....

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury..... 19.....
Where did injury occur?..... (Specify city or town, county, and State)

MOTHER 15. MAIDEN NAME

Specify whether injury occurred in industry, in home, or in public place.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Manner of injury.....

17. INFORMANT (ADDRESS)

Nature of injury.....

18. BURIAL, CREMATION, OR REMOVAL

24. Was disease or injury in any way related to occupation of deceased?.....

PLACE..... DATE..... 19.....

If so, specify.....

19. UNDERTAKER (ADDRESS)

(Signed)....., M. D.

20. FILED 9-26-35 J. J. Roberts

(Address).....

S-275-85