

1940 JUN 22 9 40 AM

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

21980
Do not use this space.

1. PLACE OF DEATH

(a) County Jasper Registration District No. 411
(b) Township Galena Primary Registration District No. 2002 Registered No. _____
(c) City Jasper Mo. (d) Street No. St. James Hospital St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. P.O. #2 Galena, Mo. St. Galena, Kansas
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9 - 16, 1940

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

22. I HEREBY CERTIFY, That I attended deceased from June 8, 1940 to June 16, 1940

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 18 - 1896

I last saw him alive on June 16, 1940 Death is said to have occurred on the date stated above, at _____ m.

7. AGE YEARS 43 MONTHS 9 DAYS 28 If LESS than 1 day, _____ hrs. or _____ min.

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

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

General Peritonitis
anemia
Date of onset _____

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

Other contributory causes of importance: Pelvic Infection

13. NAME James R. Ritchey

Blood Transfusion June 14/40

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

Name of operation permet Date of _____

15. MAIDEN NAME Hattie Baker

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

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

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)

17. INFORMANT Mrs. Hattie Craigie (ADDRESS) Carthage, Mo.

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

18. BURIAL, CREMATION, OR REMOVAL PLACE Hillcrest - Galena, Kan. DATE 6 - 18, 1940

Manner of injury _____ Nature of injury _____

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Galena, Kan.

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____ (Signed) _____, M. D.

20. FILED 6 - 17, 1940 Ed J. Jones Local Registrar

(Address) Galena, Kan.

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.

1 X14028

40-7-219

7/12/19

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
BUREAU OF HEALTH OFFICERS

MISSISSIPPI

STATE OF MISSISSIPPI

BUREAU OF HEALTH OFFICERS

MISSISSIPPI

MISSISSIPPI

MISSISSIPPI

STATE OF MISSISSIPPI

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, _____, or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **21980**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **411**

Primary Registration District No. **2002**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County: **Jackson**
(b) City or town: **Jefferson**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME: **Mrs. Lela M.R. Corbus**
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex: **F** 5. Color or race: **W**
6. (a) Single, widowed, married, divorced: **wid**
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased: _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years **43** Months **9** Days **28**
If less than one day _____ hr. _____ min.

9. Birthplace: _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace: _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace: _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof: _____ (Month) _____ (Day) _____ (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

GENERAL CERTIFICATION

20. DATE OF DEATH: Month **6** day **16**
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: **General peritonitis pneumonia**
Due to: **Cause of Relvins infection unknown -**
Due to: **Prox Pulveral - N M D**
Other condition: **Relvins infection**
(Include pregnancy within 3 months of death)
Blood Transfusion
Major findings: _____
Of operations: _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature: **A Mitchell Gragg** (M. or other)
Address: **Jefferson** Date signed _____

SUPPLEMENTAL

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

