DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 17 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 22616

Registration District No. 735 Primary Registration District No. 3034 Registrar's No. 123

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

1. PLACE OF DEATH:

(a) County: Randolph

(b) City or town: Moberly
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Woodland Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether years, months or days)

In this community 25 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Randolph

(c) City or town: Moberly
(If outside city or town limits write "RURAL")

(d) Street No. 617 So Williams
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ... years

3. (a) PRINT FULL NAME: May Kornegoor 652

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife:

6. (c) Age of husband or wife if alive ... years

7. Birth date of deceased: March (Month) 6th (Day) 1884 (Year)

8. AGE: Years 56 Months 3 Days 11 If less than one day ... hr. ... min.

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

10. Usual occupation: At home

11. Industry or business:

FATHER 12. Name: Joseph C Boulware

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

MOTHER 14. Maiden name: Nannie Goodnight

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

16. (a) Informant: E. F. Kornegoor

(b) Address: Moberly, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: June 19th 1940 (Month) (Day) (Year)

(c) Place: burial or cremation: Madison Mo

18. (a) Signature of funeral director: Mahan and Son

(b) Address: Moberly Mo

19. (a) June 19-1940 (Date received local registrar) (b) Leah Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17th year 1940 hour 2 minute 20 P.M.

21. I hereby certify that I attended the deceased from June 5, 1940, to June 17, 1940; that I last saw her alive on June 17, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Thrombosis	Duration
Due to:	
Due to:	
Other conditions: fractured right hip (Include pregnancy within 3 months of death)	June 6th
Major findings: Of operations:	PHYSICIAN — Underline the cause to which death should be charged statistically.
Of autopsy:	

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

(a) Accident, suicide, or homicide (specify): Accident

(b) Date of occurrence: June 5, 1940

(c) Where did injury occur? Moberly (City or town) Randolph (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? At home (Specify type of place)

While at work?

(e) Means of injury:

23. Signature: [illegible] (M. D. or other)

Address: Moberly, Missouri Date signed: June 19, 1940

(Licensed Embalmer's Statement on Reverse Side)

1944
96

MAY 7 1948

RECEIVED
District Health Officer No. 10
District File Number 7-40-1464
Date Filed JUL 15 1940

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 Frank D DeWitt

Licensed Embalmer No. 3021

P. O. Address Moberly - Mo

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

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

. 2B
21-40
X22659

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1. PLACE OF DEATH:
(a) County Randolph
(b) City or town Moberly
(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 years, months or days)
In this community

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.

3. (a) PRINT FULL NAME May Kornegay
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Wd
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 56 Months 3 Days 11 If less than one day h. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw h alive on , 19; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis

Due to

Due to

Duration

Other conditions (Include pregnancy within 3 months of death) Fracture of hip

Major findings:
Of operations
Of autopsy

Fell at home while walking. At work

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 Thos. L. Fleming (Attending physician or other)
Address Moberly Mo Date signed

SUPPLEMENTAL