

No. 2
11-10-39
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILLED OCT 11 1941
Registration District No. 875

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32829
Registrar's No. 264

Primary Registration District No. 6162

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

1. PLACE OF DEATH:

(a) County Vernon

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

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

(d) Length of stay: In hospital or institution one month
(Specify whether)

In this community _____
years, months or days)

3. (a) PRINT FULL NAME HIRAM E. CORNELIUS

3. (b) If veteran, name war unk. 3. (c) Social Security No. None

4. Sex Male U 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife unk. 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb 22nd 1859
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>6</u>	<u>19</u>	hr. _____ min.

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

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER

12. Name Samuel Cornelius

13. Birthplace unk. Ind.
(City, town, or county) (State or foreign country)

14. Maiden name unk. Ind.

15. Birthplace unk. Ind.
(City, town, or county) (State or foreign country)

16. (a) Informant State Hospital Records

(b) Address Nevada, Mo

17. (a) Burial (b) Date thereof 9-13-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Neva, Mo.

18. (a) Signature of funeral director Chickney Howard

(b) Address Ava Mo.

19. (a) 9-18-41 (b) Allen V. Hays
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Douglas

(c) City or town Ava
(If outside city or town limits, write "RURAL")

(d) Street No. Not known
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 11th
year 1941 7. hour 0 minute P. M.

21. I hereby certify that I attended the deceased from August 11th, 1941, to Sept 11th, 1941;
that I last saw him alive on Sept 11th, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Senile P. Psychosis

Due to _____

Due to _____

Other conditions Ch. Myocarditis
(Include pregnancy within 5 months of death)

Major findings:
Of operations _____

Of autopsy _____

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 G. S. Waraich (M. D. or other) A
Address State Hosp. No 3 Nevada Date signed 9/11/41

175 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 7,

District File Number 10-41-1750

Date Filed 10-9-41

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

W B Hutchison

Licensed Embalmer No. 3431

P. O. Address Yarnesville W

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.