

NOV 6 1943

Registration District No. **241**

Primary Registration District No. **4259-5828**

Registrar's No. **76**

1. PLACE OF DEATH:

(a) County **Steele**  
(b) City or town **Madison**  
(c) Name of hospital or institution **No**  
(d) Length of stay: In hospital or institution **One year**  
In this community **1** year, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Steele**  
(c) City or town **Madison**  
(d) Street No. **972**  
(e) Citizen of foreign country? **No**  
If yes, name country **0**

3. (a) PRINT FULL NAME

**Leo Corner**

3. (b) If veteran, name war **-**

3. (c) Social Security No. **-**

4. Sex **Male**

5. Color or race **White**

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

6. (b) Name of husband or wife **Edith M. Corner**

6. (c) Age of husband or wife if alive **31** years

7. Birth date of deceased **Dec 6, 1904**

8. AGE: Years **38** Months **20** Days **1** If less than one day **-** min.

9. Birthplace **Missouri**

10. Usual occupation

**Fanner**

11. Industry or business

**John Corner**

12. Name

**Calhoun Co. Miss**

13. Birthplace

**Martha M. Corner**

14. Maiden name

**Missouri**

15. Birthplace

16. (a) Informant

**Tom Corner**

(b) Address

**Point Pleasant Mo**

17. (a) Burial

**Yes**

(c) Place: burial or cremation

**Maury Cemetery**

18. (a) Signature of funeral director

**Walter C. Decker**

(b) Address

**Dortchville Mo**

19. (a) Date received local registrar

**Nov-1-43**

(b) Registrar's signature

**Edith Largent**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **7** year **1943** hour **9** minute **30** M.

21. I hereby certify that I attended the deceased from **Oct 7, 43 only, while he was dying** that I last saw him **alive on Oct 7, 43** and that death occurred on the date and hour stated above.

Immediate cause of death **Uraemia**

Due to **Acute Nephritis**

Due to **Gemotose malaria**

Other conditions **None**

Major findings: Of operations **28d**

Of autopsy **No**

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? **-**

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **-**

While at work? **no** (Specify type of place) (c) Means of injury **no**

23. Signature **Walter C. Decker** (M. D. or other) **0**

Address **Dortchville, Mo.** Date signed **10-8-43**

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

MOTHER FATHER

PHYSICIAN  
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Office No. 2,

District File Number 1143-1367

Date Filed 11-3-43

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 Noel C. Dean  
Licensed Embalmer No. 3941

P. O. Address Portageville  
Missouri

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, fact should be so stated above.