

FILED JAN 8 1946 STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1409

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 8 days  
(Specify whether \_\_\_\_\_)

In this community life  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")

(d) Street No. 1301 Penn  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Grace Cornish

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex female 5. Color or race white

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

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased July 5 1883  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>	<u>5</u>	<u>22</u>	hr. _____ min. _____

9. Birthplace St. Joseph Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

12. Name Harvey Cornish

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

14. Maiden name Pernitia Bevelle

15. Birthplace unknown Iowa  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Lorene Grumwald

(b) Address St. Joseph, Mo.

17. (a) burial (b) Date thereof 12/29/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Mora

18. (a) Signature of funeral director Healer B. Sale & Bowman

(b) Address 319 South 10th

19. (a) Jan 2-1946 (b) A. J. Methman  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 27  
year 1945 hour 4 minute 15 A. M.

21. I hereby certify that I attended the deceased from 11/23/1945  
to 12/27/45, 19\_\_\_\_, to 19\_\_\_\_;  
that I last saw her alive on 12/26/45, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia, terminal, 9 days  
Polycystic Kidneys (?)

Due to Cortical Tumors of the  
Adrenal Glands and  
adenomas of the Pituitary  
glands (?)

Other conditions Diabetes 8 yrs.  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations no operation

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)

23. Signature London D. Wright M.D. (M. D. or other)

Address 845 S. 19th, St. Joe, Mo Date signed 12/29/45

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

MOTHER FATHER

Per H.O. Wright  
845 Dec 19 46

**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 27 Dec 46  
....., Registered Apprentice No. ✓  
working under my personal supervision.

Signed Harold Bowman

Licensed Embalmer No. 3619

P. O. Address St. Joseph, Mo

**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.