

FILED DEC 2 1946

Registration District No. 357

Primary Registration District No. 4-5-16-6-199

Registrar's No. 94

1. PLACE OF DEATH: *Janey*
 (a) County *Janey*
 (b) City or town *Forsyth Rural*
 (c) Name of hospital or institution: *1*
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution *1 yr.* (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State *Mo* (b) County *Janey*
 (c) City or town *Forsyth Rural*
 (If outside city or town limits, write "RURAL")
 (d) Street No. (If rural, give location)
 (e) Citizen of foreign country? *No.* (Yes or No)
 If yes, name country:

3. (a) PRINT FULL NAME *CLARA AVIS CORNELISON*
 3. (b) If veteran, name war: 3. (c) Social Security No.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month *November* day *7* year *1946* hour *1* minute *30 A.* M.
 21. I hereby certify that I attended the deceased from *May*, 19*44* to *November 7*, 19*46*.
 that I last saw her alive on *November 6*, 19*46*.
 and that death occurred on the date and hour stated above.

4. Sex *Female* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *married*
 6. (b) Name of husband or wife *James C. Cornelison* 6. (c) Age of husband or wife if alive *54* years
 7. Birth date of deceased *May* *29* *1896*
 (Month) (Day) (Year)

Immediate cause of death *Chronic poisoning*
 Duration

8. AGE: Years *50* Months *6* Days *8* If less than one day hr. min.

Due to *Chronic to subacute Cardiorenal disease*
 Due to

9. Birthplace *Deer Co. Mo.* (City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation *Housewife*

Major findings: Of operations *131A*
 Of autopsy

11. Industry or business
 12. Name *James Biggs*
 13. Birthplace *unknown* (City, town, or county) (State or foreign country)
 14. Maiden name *Louella Ruffell*
 15. Birthplace *unknown* (City, town, or county) (State or foreign country)

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

16. (a) Informant *James C. Cornelison*
 (b) Address *Forsyth Mo.*
 17. (a) *Burial* (b) Date thereof *Nov. 10, 1946*
 (Burial, cremation, or removal) (Month) (Day) (Year)

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?

(c) Place: burial or cremation *Forsyth Cemetery*
 18. (a) Signature of funeral director *Edmar C. Forsyth*
 (b) Address *Forsyth Mo.*
 19. (a) *11-20-46* (b) *C. H. Allaman*
 (Date received local registrar) (Registrar's signature)

While at work? (Specify type of place) (e) Means of injury *0*
 23. Signature *H. Clapp* (M: D. or other)
 Address *Forsyth, Missouri* Date signed *11-7-46*

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

RECEIVED

District Health Officer No. 6,

District File Number 1146-1182

Date Filed NOV. 29. 1946

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, ^{and} by _____

Elmer C. Forsyth, Registered Apprentice No. 421
working under my personal supervision.

Signed Minnie L. Wheelchel.

Licensed Embalmer No. 2277

P. O. Address Branson 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.

Registration District No. 351

Primary Registration District No. 6189

1. PLACE OF DEATH:

(a) County Janey Rural
(b) City or town Rural
(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

Clara A. Cornelius

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 m

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

7. Birth date of deceased May 29
(Month) (Day) (Year)

8. AGE: Years 50 Months 6 Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business HOUSEWIFE

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) _____ (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) _____ (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 19 Hour _____ minute _____ M.

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

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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) (c) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

39378