S. No. 2

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 5 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1649

Registration District No. 172 Primary Registration District No. 4269 Registrar's No. 5

1. PLACE OF DEATH:
(a) County: Lafayette
(b) City or town: Corder
(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: Mo (b) County: Lafayette
(c) City or town: Corder
(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

3. (a) PRINT FULL NAME: Mrs Margaret G. Corder
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: Widowed
6. (b) Name of husband or wife: Welsh Corder
6. (c) Age of husband or wife if alive: years
7. Date of birth of deceased: Sept (Month) 14 (Day) 1861 (Year)

8. AGE: Years 85 Months 3 Days 25 If less than one day hr. min.

9. Birthplace: Lewis County Mo. (City, town, or county) 0 (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business:
MOTHER FATHER
12. Name: Joseph Trotter.
13. Birthplace: Virginia (City, town, or county) (State or foreign country)
14. Maiden name: Martha Dale
15. Birthplace: Lewis County Mo. (City, town, or county) 0 (State or foreign country)
16. (a) Informant: W. L. Corder
(b) Address: Corder Mo.
17. (a) burial (Burial, cremation, or removal) (b) Date thereof: 1-12-1947 (Month) (Day) (Year)
(c) Place: burial or cremation: Corder Mo.
18. (a) Signature of funeral director: [illegible]
(b) Address: Higginsville Mo.
19. (a) Jan 16-47 (Date received local registrar) (b) Clayton H. Landrum (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 9th year 1947 hour 7 minute 50 P.M.
21. I hereby certify that I attended the deceased from Sept 5 1945, to Jan 9 1947 that I last saw her alive on Jan 9 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Embolism and Thrombosis. — Duration
Due to: High Blood Pressure
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations: 0
Of autopsy: 0

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? (Specify type of place)
While at work?
(e) Means of injury:
23. Signature: Leon L. Spencer (M. D. or other) MD
Address: Higginsville Mo Date signed 1-12-47

154 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number.....
Date Filed 1-25-47

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 [illegible]

Licensed Embalmer No. 539

P. O. Address Higginsville 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.

S. No. 2B
M—3-45.
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 7 et

Registration District No. 172 Primary Registration District No. 4269 Registrar's No. 5

1. PLACE OF DEATH:
(a) County Lafayette
(b) City or town Corder
(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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Margaret G. Corder
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 Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept (Month) 14 (Day) 1886 (Year)
8. AGE: Years 85 Months 3 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
MOTHER FATHER
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) (Date received local registrar) (b) Clayton H. Landrum (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day
year 1947 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.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

5-1649