

S. No. 2
M-5-43
5-17-39
X3671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 21 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **19938**

Registration District No. **371**

Primary Registration District No. **4542**

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County **Webster**
 (b) City or town **Rogersville**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **X**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **X** / **9**
(Specify whether years, months or days)
 In this community **life**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Webster** / **12**
 (c) City or town **Rogersville** / **0**
(If outside city or town limits, write "RURAL") / **6**
 (d) Street No. **X** / **0**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country **X**

3. (a) PRINT FULL NAME **Philip Corn**
 (b) If veteran, name war **X**
 (c) Social Security No. **442-05-3864**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **May** day **8**
 year **1947** hour **10** minute **30** A.M.

4. Sex **Male** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **married**
 6. (b) Name of husband or wife **Esther Corn**
 6. (c) Age of husband or wife if alive **37** years
 7. Birth date of deceased **March-29-1900**
(Month) (Day) (Year)

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.

8. AGE: Years **47** Months **1** Days **9**
 If less than one day **X** hr. **X** min.

Immediate cause of death **Electric Shock** Duration _____
 Due to **Coming in Contact with electric wire accidentally while working on electric power line**
 Other conditions (include pregnancy within 3 months of death) _____
 Major findings: **193'**
 Of operations _____
 Of autopsy _____

9. Birthplace **Missouri** (City, town, or county) (State or foreign country)
10. Usual occupation **Electrician**
11. Industry or business **Power line**
MOTHER FATHER
12. Name **Philip Corn**
13. Birthplace **Tennessee** (City, town, or county) (State or foreign country)
14. Maiden name **Nancy Watson**
15. Birthplace **Missouri** (City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) **Accident**
 (b) Date of occurrence **May 8-1947** / **112**
 (c) Where did injury occur? **Rogersville Webster, Mo**
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

16. (a) Informant **Mrs. Esther Corn**
(b) Address **Marshfield, Mo.**
17. (a) Burial (b) Date thereof **5-11-'47**
(Burial, cremation, or other) (Month) (Day) (Year)
(c) Place: burial or cremation **Willow Springs**
18. (a) Signature of funeral director **W. J. Jolley**
(b) Address **Marshfield, Mo.**
19. (a) 6-10-47 (b) **Last of Good**
(Date received local registrar) (Registrar's initials)

While at work? **Yes** (Specify type of place) (c) Means of injury _____
23. Signature **W. J. Jolley** **Coroner** **Webster, Mo** / **3**
(M. D. or other)
Address **Portland, Mo** **Date signed** **5-9-47**

(Licensed Embalmer's Statement on Reverse Side)

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

11-47

0

0

0

0

0

0

0

0

JAN 12 1948

MAY 24 1948

MAY 22 1948

MAY 10 1948

1 X
2 M - 3 N
3 B

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 Alex Rainey

Licensed Embalmer No. 3312

P. O. Address Marshfield, 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.

1000 11502

Registration District No. 371 Primary Registration District No. 4542

1. PLACE OF DEATH:
(a) County Webster
(b) City or town Rogersville
(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 _____ years, months or days

3. (a) PRINT FULL NAME Philip Corn
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 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 _____ years

7. Birth date of deceased march 29 (Month) (Day) (Year)
8. AGE: Years 47 Months _____ Days _____ (If less than one day) hr. _____ min. mo

9. Birthplace _____ (City, town, or county) (State or foreign country)
10. Usual occupation _____
11. Industry or business _____
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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation)
18. (a) Signature of funeral director _____ (b) Address _____
19. (a) 6-10-47 (b) Peter D. Good (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 1947 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____ that I last saw him _____ alive on _____ 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) (e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

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

S-19938