

FILED JUL 29 1947

0376

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County De Kalb
(b) City or town Grand River (rural)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 11
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 4 years years, months or days

3. (a) PRINT FULL NAME

Ethel Selenia Corlile

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female

5. Color or race W

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

6. (b) Name of husband or wife

George Corlile

6. (c) Age of husband present or

alive 60 years

7. Birth date of deceased

September 2, 1894

(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

52

6

26

hr.

min.

9. Birthplace

Harrison Co

(City, town, or county)

Iowa

(State or foreign country)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

John T. Killpatrick

13. Birthplace

Neolia

(City, town, or county)

Iowa

(State or foreign country)

14. Maiden name

Georgia Anna Chapman

15. Birthplace

Neolia

(City, town, or county)

Iowa

(State or foreign country)

16. (a) Informant

Glenn Sherman

(b) Address

Cameron, Mo.

17. (a)

Burial

(Burial, cremation, or removal)

(b) Date thereof

July 16, 1947

(c) Place: burial or cremation

Calvin Cemetery

18. (a) Signature of funeral director

John J. Funeral Home

(b) Address

Cameron, Mo.

19. (a)

(Date received local registrar)

(b)

R. Jackson

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County De Kalb
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. Rural near Cameron (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

23. DATE OF DEATH: Month July day 13
year 1947 hour 11 minute 15 A.M.

24. I hereby certify that I attended the deceased from _____

_____ 19____ to _____ 19____
that I last saw her alive on _____
and that death occurred on the date and hour stated above.

Immediate cause of death drowning

Duration

Due to mental condition

Due to _____

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy 7035

PHYSICIAN

Underline the cause to which death should be charged statistically.

25. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) suicide

(b) Date of occurrence July 13-1947

(c) Where did injury occur? Rural near Cameron Mo. (City or town) (County) (State)

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

On farm of home owned.

(e) Means of injury _____

26. Signature Mrs. Gale (M.D. or other)

Address Osborne 1770 Date signed 7/13/47

DISTRICT HEALTH OFFICE
Camero, Mo.

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

George B. Trammell

Licensed Embalmer No. *4425*

P. O. Address. *309 1/2 N. 2nd*

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: