S. No. 2
M—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 28 1947

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 39541

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10605

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

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: ST. LUKES HOSP.
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State ILLIONIS (b) County MARION 999

(c) City or town CENTRALIA
(If outside city or town limits, write "RURAL")

(d) Street No. 337 So. ELM.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME BESSIE W. CORNELL

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex FEMALE

5. Color or race WHITE

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

6. (b) Name of husband or wife E.A. CORNELL

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

7. Birth date of deceased JULY (Month) - 29 (Day) - 1869 (Year)

8. AGE:

Years	Months	Days	If less than one day
78	3	10	hr. min.

9. Birthplace FARINA (City, town, or county) ILL (State or foreign country)

10. Usual occupation HOUSEKEEPER

11. Industry or business OWN HOME

FATHER
12. Name JAMES NORTON
13. Birthplace — (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name MARY E. IRISH
15. Birthplace — (City, town, or county) NEW YORK (State or foreign country)

16. (a) Informant MR. I. GARNIER
(b) Address CENTRALIA, ILL.

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 11-11-47 (Month) (Day) (Year)
(c) Place: burial or cremation CENTRALLIA ILL

18. (a) Signature of funeral director ROWLAND FUNERAL SER
(b) Address 4355 WASHINGTON AV.

19. (a) (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 9th
year 1947 hour 12 minute 50 P M.

21. I hereby certify that I attended the deceased from 11-3-47, 19, to 11-9, 1947
that I last saw her alive on 11-9, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Squamous Carcinoma of Nose with excursion to sphenoid sinus (INternal) — Duration 6 yrs

Due to

Due to

Other conditions Hypertension [illegible] arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations As above
Of autopsy none done

PHYSICIAN
Underline the cause of 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 Louis H Jorstad (M. D. or other)

Address 3720 Washington St Louis. Mo Date signed 10/10/47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

Louis H Jorstad

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.

10605

Signed Jan M Sizemore

Licensed Embalmer No. 4343

P. O. Address St. Louis 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.