

No. 2  
12-45  
17-39  
X47070

FILED DEC 31 1947  
Registration District No. **277**

Primary Registration District No. **5787**

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

1. PLACE OF DEATH:

(a) County Mississippi

(b) City or town Charleston (Rural)  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Route 2, Box 177  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 weeks  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Mary Corner

3. (b) If veteran, name war -----

3. (c) Social Security No. -----

4. Sex Female 5. Color or race Negro

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

6. (b) Name of husband or wife Will Corner

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

7. Birth date of deceased Unknown About 1877  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
About 70	---	---	---	hr. min.

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

10. Usual occupation Housewife

11. Industry or business -----

12. Name Unknown

13. Birthplace Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Betty Robinson

15. Birthplace Miss.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Emma Burgess

(b) Address R. 2, Box 177, Charleston, Mo.

17. (a) Removal (b) Date thereof Dec. 13, 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Macon, Miss.

18. (a) Signature of funeral director F. S. Sparks

(b) Address Charleston, Mo.

19. (a) 12-13-47 (b) Mrs. J. B. Bondurant  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mississippi (b) County Jones

(c) City or town Macon (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 -----

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 11  
year 1947 hour 1: minute 45 A. M.

21. I hereby certify that I attended the deceased from Dec 8, 1947, to Dec 11, 1947, that I last saw her alive on Dec 8, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to arteriosclerotic arterio-sclerotic hypertension

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:

(c) 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? 0

While at work? ----- (Specify type of place) (c) Means of injury -----

23. Signature William L. Davis (M. D. or other) MD

Address Charleston, Mo. Date signed 12-13-47

999  
92  
9

Duration  
4 days

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

RECEIVED

District Health Office No. 2,

District File Number 1247-1639

Date Filed 12-29-47

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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 Frank Sparks

Licensed Embalmer No. 3455

P. O. Address Cape Girardeau 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.