

Registration District No. 157

Primary Registration District No. 3028

Registrar's No. 153

1. PLACE OF DEATH:

(a) County Jasper

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

(c) Name of hospital or institution: McCune Brooks Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Days
(Specify whether)

In this community Lifetime
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper

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

(d) Street No. Route #4
(If rural, give location)

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

If yes, name country None

3. (a) PRINT FULL NAME Joseph Frerer CORNELL

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male 0
5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased June 19, 1948
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
0	0	2	hr. min.

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

10. Usual occupation None

11. Industry or business None

12. Name Harry Mack Cornell Jr.

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

14. Maiden name Shirley Frerer

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

16. (a) Informant Mr. Harry M. Cornell Jr.

(b) Address Route #4 Carthage, Mo.

17. (a) Burial (b) Date thereof 6-24-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Cemetery

18. (a) Signature of funeral director Ed. C. Ulmer

(b) Address Carthage, Mo.

19. (a) 6-22-48 (b) L.B. Clinton
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21st
year 1948 hour 9:00 minute P.

21. I hereby certify that I attended the deceased from June 19, 1948, to June 21, 1948; that I last saw him alive on June 21, 1948; and that death occurred on the date and hour stated above.

Immediate cause of death Thrombocytopenia - (6 ma) Duration 2 days

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Charles H. Schell (M.D. or other) MD

Address 201 W. 3rd, Carthage, Mo Date signed June 23, 1948

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

MOTHER FATHER

48-6-525

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 _____
Gene. C. Pugh.

Licensed Embalmer No. 4231

P. O. Address Carthage, 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.

Registration District No. 157

Primary Registration District No. 8028

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Carthage
(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 _____ (Specify whether _____)
years, months or days

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 Joseph F. Cornell
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 _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ (Less than one day) _____ hr. _____ min.

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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 6-22-48 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1948 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; 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

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

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

MOTHER FATHER

S-19808