

FILED OCT 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34833

State File No.

BIRTH NO. _____ REG. DIST. NO. 314 PRIMARY REG. DIST. NO. 6052 Registrar's No. 43

1. PLACE OF DEATH a. COUNTY St. Clair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Clair	
b. CITY (If outside corporate limits, write RURAL and give township) Collins (Rural)		c. CITY (If outside corporate limits, write RURAL and give township) Collins (Rural)	
c. LENGTH OF STAY (in this place) 30		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2 mi. N.E. Collins Mo			

3. NAME OF DECEASED a. (First) Minerva b. (Middle) F. c. (Last) Corbett			4. DATE OF DEATH (Month) (Day) (Year) 9/27/49		
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5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH 2/22/1864		9. AGE (In years last birthday) 85		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeping			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Keokuk Mo.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
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13a. FATHER'S NAME Nathan Parks			13b. MOTHER'S MAIDEN NAME Minerva Desmore			14. NAME OF HUSBAND OR WIFE -----		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Anna Spencer Coccini Mo.				ADDRESS	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Inflammation of red eye							
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						794X	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? - YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from Feb 10, 1947, to Sept 27, 1949, that I last saw the deceased alive on Sept 1, 1949, and that death occurred at 9:30 AM from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. E. D. Brown Do Collins Mo.			23b. ADDRESS		23c. DATE SIGNED 9-28-49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10/1/49		24c. NAME OF CEMETERY OR CREMATORY Robinson Cemetery		24d. LOCATION (City, town, or county) (State) Collins Mo.	
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DATE REC'D BY LOCAL REG. 10-1-49		REGISTRAR'S SIGNATURE Kath Seavers		25. FUNERAL DIRECTOR'S SIGNATURE J.B. ...		ADDRESS	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
District Health Officer No. _____
District File Number 9-49-12
Date Filed 10-26-4

NOV 8 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed J. B. Goodrich

Licensed Embalmer No. 3038

P. O. Address Osceola, 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.