

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29389**

FILED SEP 15 1953

BIRTH NO. _____ REG. DIST. NO. **233** PRIMARY REG. DIST. NO. **4348** Registrar's No. **16**

200

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

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Montgomery	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Wellsville		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Wellsville	
c. LENGTH OF STAY (in this place) 4 years		d. STREET ADDRESS (If rural, give location) 105 Madison	
d. FULL NAME OF HOSPITAL OR INSTITUTION 105 Madison		d. STREET ADDRESS (If rural, give location) 105 Madison	

3. NAME OF DECEASED (Type or Print)	a. (First) BESSIE	b. (Middle) ELIZABETH	c. (Last) CORNELIUS	4. DATE OF DEATH (Month) (Day) (Year) Sept. 5 1953
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan 22 1884	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR: Months 7 Days 14	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY House work		11. BIRTHPLACE (State or foreign country) Montgomery County, Mo.		12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME Cornelius Mabry	13b. MOTHER'S MAIDEN NAME Mintie Johnson	14. NAME OF HUSBAND OR WIFE Frank Cornelius
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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) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Frank Cornelius Wellsville Mo.	ADDRESS Wellsville Mo.
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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, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 24 hrs 1 year
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis		
	ANTECEDENT CAUSES DUE TO (b) Diabetes DUE TO (c) Obesity		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) 260X
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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 **Sept 4, 1953** to **Sept 5, 1953**, that I last saw the deceased alive on **9/5, 1953**, and that death occurred at **4:30 A. M.**, from the causes and on the date stated above.

23a. SIGNATURE Walter H. W. Bell	(Degree or title)	23b. ADDRESS Wellsville	23c. DATE SIGNED 9/5/53
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24a. BURIAL, CREMATION, REINBURSEMENT (Specify)	24b. DATE 9/7/53	24c. NAME OF CEMETERY OR CREMATORY Wellsville City Cem.	24d. LOCATION (City, town, or county) (State) Wellsville, Missouri
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DATE REC'D BY LOCAL REG. 9-8-53	REGISTRAR'S SIGNATURE W.S. Romano Jr. 422	25. FUNERAL DIRECTOR'S SIGNATURE B.B. Wells	ADDRESS Wellsville Mo
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SEP 16 1953

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

A. B. Kullb

Licensed Embalmer No. *1588*

P. O. Address

Wellsville 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.