

FILED NOV 18 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38117

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9949**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) c. CITY OR TOWN <b>St. Louis</b> d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>7 4123a Marcus Avenue. 207/0</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>KATHRYN</b>	b. (Middle) <b>MARY</b>	c. (Last) <b>CORNOYER</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 14, 1955</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Apr. 27, 1888</b>	9. AGE (in years last birthday) <b>67</b>	IF UNDER 1 YEAR Months Days	IF UNDER 4 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telephone Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>S. W. Bell</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>Patrick Gleason</b>	13b. MOTHER'S MAIDEN NAME <b>Mary E. Finnegan</b>	14. NAME OF HUSBAND OR WIFE <b>Lawrence Cornoyer</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>488-07-5022</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Mary Jackson</b>	ADDRESS <b>4123 Marcus Ave.</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Gasping Ulcer</b>		<b>1 mo.</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		<b>540.0</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>morsem 99 hemorrhage</b>			<b>1 mo.</b>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>No Ulcer noted - Autopsy revealed ulcer</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/>	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) <b>11:30A</b>	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 **Oct 22, 1955**, to **Nov 14, 1955**, that I last saw the deceased alive on **Nov 14, 1955**, and that death occurred at **11:30A** m., from the causes and on the date stated above.

23a. SIGNATURE <b>Chorvick M.D.</b>	(Degree or title)	23b. ADDRESS <b>408 Humboldt Bldg.</b>	23c. DATE SIGNED <b>11-15-55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>11/17/55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
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DATE REC'D BY LOCAL REG. <b>NOV 15 1955</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN STYGAR and SON FUNERAL HOME</b>	ADDRESS <b>5541 Riverview Dr.</b>
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S.P. (Licensed Embalmer's Statement on Reverse Side)

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

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.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 398

P. O. Address St. Louis

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.