

FILED DEC 28 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39841

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>47</u>		PRIMARY REG. DIST. NO. <u>3008</u>		Registrar's No. <u>337</u>		
1. PLACE OF DEATH a. COUNTY <u>Callaway</u>				2. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>				
b. CITY (If outside corporate limits, write RURAL, and give township) <u>Fulton</u>		c. LENGTH OF STAY in this place (Township) <u>35 yrs</u>		c. CITY OR TOWN <u>Fulton</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hosp. #1</u>				e. STREET ADDRESS (If rural, give location) <u>3628 Cuba Ave</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Nellie</u> b. (Middle) <u>D.</u> c. (Last) <u>Corwin</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>12 18 55</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>		8. DATE OF BIRTH <u>March 4 1887</u>		
9. AGE (In years last birthday) <u>68</u>		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of the life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Joseph Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Peter Sabig</u>			13b. MOTHER'S MAIDEN NAME <u>Mamie Miller</u>			14. NAME OF HUSBAND OR WIFE <u>Dr</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Dr. Ross Fulton, Mo.</u> ADDRESS <u>Fulton, Mo.</u>				
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Advanced Carcinoma</u> ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) <u>Probable Carcinoma of uterus</u> rise to the above cause (a) stating the underlying cause last. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>174X</u>					INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <u>3-1</u> , 19 <u>46</u> , to <u>12-18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-18</u> , 19 <u>55</u> , and that death occurred at <u>8:50 p.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Wm. L. Crum</u> M.D.				23b. ADDRESS <u>State Hosp #1</u>		23c. DATE SIGNED <u>12-18-55</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>12-21-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>State Hosp No 1</u>		24d. LOCATION (City, town, or county) (State) <u>Fulton Mo</u>		
DATE REC'D BY LOCAL REG. <u>Dec. 20-1955</u>		REGISTRAR'S SIGNATURE <u>Martha Lawrence</u> <u>426-5</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R.P. Winks</u>		ADDRESS <u>Fulton, Mo</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

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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 ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.