

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

22836

STATE FILE NUMBER

854

FILED AUG 13 1956

42

1000

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>Buchanan</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		a. STATE <b>Missouri</b>		b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Methodist Hospital</b>		Length of stay in lb <b>15yrs</b>		d. STREET ADDRESS <b>52-1/2 Ayrlawn</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <b>ROY</b>		Middle <b>S.</b>		Last <b>CORMAN SR.</b>		Month Day Year <b>August 6 1956</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>January 17, 1893</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Utility Man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Artesian Ice Co.</b>		11. BIRTHPLACE (City and state or country) <b>Near Lexington Kentucky</b>		9. AGE (In years last birthday) <b>63</b>	
13. FATHER'S NAME <b>Surber Corman</b>				14. MOTHER'S MAIDEN NAME <b>Unk. Murphy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yrs. give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>509-18-0983</b>		17. INFORMANT <b>Dr. Vern Corman</b>		Address <b>Savannah, Mo.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolus</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 min.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) _____							
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cerebral Thrombosis --- 3 days</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>332x</b>				
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>Jul. 31, 1956</b> to <b>Aug. 6, 1956</b> and last saw her <sup>her</sup> alive on <b>Aug. 6, '56</b> Death occurred at <b>10:30 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Sharon E. Wagoner</i>				22b. ADDRESS <b>301 Illinois Ave. City</b>		22c. DATE SIGNED <b>8-7-56</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8-10-56</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Joseph Missouri</b>	
24. FUNERAL DIRECTOR <i>Home Funeral Home</i>				25. DATE RECD. BY LOCAL REG. <b>August 10, 1956</b>		26. REGISTRAR'S SIGNATURE <i>E. M. Allison</i>	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

AUG 28 1956

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 *Charles E. Bennett*

Licensed Embalmer No. *462*

P. O. Address *St. Joseph*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.