

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26157

FILED AUG 16 1956

State File No. _____
Registrar's No. 419

BIRTH NO. _____		REG. DIST. NO. <u>43</u>		PRIMARY REG. DIST. NO. <u>3007</u>		Registrar's No. <u>419</u>	
1. PLACE OF DEATH a. COUNTY <u>Butler</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Poplar Bluff</u>			c. LENGTH OF STAY (in this place) <u>5 wks.</u>		c. CITY OR TOWN <u>Bloomfield</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION - <u>Poplar Bluff Hospital</u>				e. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ADA</u>			b. (Middle) <u>R.</u>		c. (Last) <u>CORBIN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 3, 1956</u>
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>Sept. 13, 1879</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Days <u>10</u>	IF UNDER 4 HRS. Hours <u>20</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Astoria, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Jack Carnall</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Cossairt</u>		14. NAME OF HUSBAND OR WIFE <u>Dr. Riley Corbin, Deceased</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 ADDRESS <u>Robt. Cossairt, Bloomfield, 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, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>leaking stomach</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION <u>July 15, 1956</u>		19b. MAJOR FINDINGS OF OPERATION <u>leaking stomach</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
11a. ACCIDENT SUICIDE HOMICIDE _____		11b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>151X</u>			
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? _____			
22. I hereby certify that I attended the deceased from <u>July 14, 1956</u> , to <u>Aug 3, 1956</u> , that I last saw the deceased alive on <u>July 31, 1956</u> , and that death occurred at <u>11:15 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Ed Muehleisen M.D.</u>				23b. ADDRESS <u>Poplar Bluff Mo</u>		23c. DATE SIGNED <u>8/6/56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug. 6/56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Bloomfield cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Bloomfield, Missouri</u>		
DATE REC'D BY LOCAL REG. <u>8/10/56</u>		REGISTRAR'S SIGNATURE <u>Ed Muehleisen</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>CHILES UND. CO. BLOOMFIELD, MO.</u>			

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

489-

RECEIVED
AUG 13 1956
BUTLER CO. HEALTH CENTER
FILE No. _____

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, & by Lulu Cooper # 3499 ~~Student Embalmer No.~~
~~working under my personal supervision.~~

Student
Signature of Student Embalmer

Signed Ivan E. Cooper

Licensed Embalmer No. 4119

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