

FILED JAN 21 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHSTATE FILE NUMBER **286**Registration District No. **42** Primary Registration District No. **1000** Registrar's No. **23**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph 0110
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Meth. Hosp.		Length of stay in lb 1 day	d. STREET ADDRESS (If outside, give location) R. R. #1
3. NAME OF DECEASED (Type or print) First DELLA Middle MAE Last CORNELIUS			4. DATE OF DEATH Month Jan. Day 7 Year 1957
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (City and state or country) Buchanan County, Mo.
13. FATHER'S NAME James Bernond		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Mr. Ben Cornelius, R.R. #1, St. Joseph, Mo.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerotic heart disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia, Parkeston, progesterone			INTERVAL BETWEEN ONSET AND DEATH 2 days unknown
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.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1-6-57 to 1-7-57 and last saw her alive on 1-7-57 Death occurred at 9:30a. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) W. H. Allison, M.D.		22b. ADDRESS 902 Edward St	22c. DATE SIGNED 1-9-57
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 1/9/1957	23c. NAME OF CEMETERY OR CREMATORY Blakely Cemetery
24. FUNERAL DIRECTOR Heaton-Bowman		23d. LOCATION (City, town, or county) (State) Buchanan County, Mo.	25. DATE RECD. BY LOCAL REG. Jan 14, 1957
26. REGISTRAR'S SIGNATURE Heaton M. Allison		26. REGISTRAR'S SIGNATURE	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

000-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

850

Dr. Amos

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 *James P. Hawken*
Licensed Embalmer No. 453

P. O. Address 319 So. 10th

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.