

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 7 1960

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-60-005181  
STATE FILE NUMBER

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

|  |  |   |  |  |   |  |   |  |
|--|--|---|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Buchanan</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> COUNTY <b>Buchanan</b> |   |  |   |  |
| b. CITY (if outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Joseph</b>   |  | Length of stay in 1b<br><b>1 day</b>  |  | c. CITY OR TOWN <b>Easton</b>  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |   |  |
| c. FULL NAME OF (if NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Mo. Meth. Hospital</b>   |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  | d. STREET ADDRESS (if outside, give location)<br><b>R#1.</b>  |  | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>John</b> Middle <b>Calvin</b> Last <b>Cornelius</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>February</b> Day <b>27</b> Year <b>1960</b>   |   |  |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 26, 1873</b>   | 9. AGE (last birthday)<br><b>86</b>  | IF UNDER 1 YEAR<br>Months _____ Days _____                    | IF UNDER 24 HR<br>Hours _____ Min. _____   |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Ret. Farmer</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Agriculture</b>   |  | 11. BIRTHPLACE (City and state or country)<br><b>Buchanan Co., Mo.</b>   |   | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>  |   |  |
| 13a. FATHER'S NAME<br><b>William B. Cornelius</b>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Mary Jane Wilson</b>                                 |  | 14. NAME OF HUSBAND OR WIFE<br><b>Ollie Sampson Cornelius</b> |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |  | 17. INFORMANT<br><b>Mrs. Effie Wertemberger-St. Joseph,</b><br>Address <b>Mo.</b>  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Fracture skull left temporal</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Fracture left femur &amp; tibia</b><br>DUE TO (c) <b>Internal injuries</b> |  |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>1 day</b><br><b>1 day</b>   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  |  |   |  |  |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20a. ACCIDENT <input checked="" 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.)<br><b>Struck by Car on Highway P. Buchanan Co.</b>             |  |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Hour <b>11:30</b> a.m. Month, Day, Year <b>2-27-60</b>  |  | 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.)<br><b>Highway</b>                               |   | 20f. CITY, TOWN, OR LOCATION<br><b>Buchanan Mo</b>   |   |  |
| 21. I attended the deceased from _____ to _____ and last saw him alive on _____<br>Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.  |  | 1:45 P. to 145 PM and last saw him alive on 2.27.60   |  |  |   |  |   |  |
| 22a. SIGNATURE<br><i>[Signature]</i> (Degree or title)   |  |   |  | 22b. ADDRESS<br><b>St Joseph Mo</b>  |   | 22c. DATE SIGNED<br><b>2.27.60</b>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>Mar. 1, 1960</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bowen Cemetery</b>  |   | 23d. LOCATION (City, town, or county) (State)<br><b>Buchanan Co., Missouri.</b>  |   |  |
| 24. FUNERAL DIRECTOR<br><i>[Signature]</i><br><b>St. Joseph, Mo. Mar. 3, 1960</b>  |  |   | 25. DATE RECD. BY LOCAL REG.   |  | 26. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>               |  |   |  |

DOCUMENT

P.A. Knepper, Medical Certification

BY AFFIDAVIT OF

JUN 3 1960

MAY 12 1960

MAY 25 1960

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 Edward R. Farrington

Licensed Embalmer No. 3258

P. O. Address H. J. [unclear]

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.