

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-027609

FILED VS AUG 4 1960

209

Primary Registration District No. 3043

Registrar's No. 304

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>Marion</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Monroe</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hannibal</b>		Length of stay in 1b <b>2 Days</b>	c. CITY OR TOWN <b>Stoutsville</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>St Elizabeth Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Hy. 36 R R # 2</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>Homer Clarence Corder</b>			4. DATE OF DEATH Month Day Year <b>July 27, 1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6/5/1885</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR Months Days <b>1 22</b>	IF UNDER 24 HR Hours Min. <b>22</b>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Farming</b>	11. BIRTHPLACE (City and state or country) <b>Ely Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
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13a. FATHER'S NAME <b>Vincent S. Corder</b>		13b. MOTHER'S MAIDEN NAME <b>Permelia Tuley</b>		14. NAME OF HUSBAND OR WIFE <b>Mrs. Ruby L. Corder</b>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>489-42-1591</b>	17. INFORMANT Address <b>Mrs. Ruby L. Corder. Stoutsville Mo</b>		
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:				INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Terminal pneumonia</b>				<b>one day</b>	
DUE TO (b) <b>Cerebral vascular accident</b>				<b>three days</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)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)	
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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 checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Stoutsville</b>	COUNTY <b>Monroe</b>	STATE <b>Mo</b>
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21. I attended the deceased from **July 25, 1960** to **July 27, 1960** and last saw him alive on **July 27, 1960**  
Death occurred at **4:15 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Dr. E. M. Duke by Delegation</i> M D		22b. ADDRESS <b>707 Bdwy, Hannibal, Missouri</b>		22c. DATE SIGNED <b>7-29-60</b>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7/29/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Judes Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Monroe City, Mo.</b>		
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24. FUNERAL DIRECTOR ADDRESS <b>Harold V. Garner. Monroe City Mo</b>		25. DATE RECD. BY LOCAL REG. <b>8/1/60</b>	26. REGISTRAR'S SIGNATURE <i>Dr. E. M. Duke by Delegation</i> <i>M. Gleason</i>		
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Nancy Farnsworth

Licensed Embalmer No. 3720

P. O. Address Monroe

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