

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**=63-005010**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 50

STATE FILE NUMBER

**FILED FEB 18 1963**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION *Autopsy not*

1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Adair</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirksville</b>		Length of stay in 1b <b>years</b>	c. CITY OR TOWN <b>Kirksville</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Kirksville Osteopathic</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1002 E. Randolph St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>WILLIAM</b> Last <b>CORNELL</b>			4. DATE OF DEATH Month <b>February</b> Day <b>9</b> Year <b>1963</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>9/13/73</b>
9. AGE (last birthday) <b>89</b>		IF UNDER 1 YEAR Months Days Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired farmer</b>
10b. KIND OF BUSINESS OR INDUSTRY <b>farming</b>		11. BIRTHPLACE (City and state or country) <b>Adair County, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U S</b>
13a. FATHER'S NAME <b>Sebastin Cornell</b>		13b. MOTHER'S MAIDEN NAME <b>Margaret Pring</b>	14. NAME OF HUSBAND OR WIFE <b>Iva Shupp Cornell</b>
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>No</b>	17. INFORMANT Address <b>Iva Cornell, Kirksville, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral arteriosclerosis unknown</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>15 min</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. <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.)	
20c. TIME OF INJURY Hour a.m. p.m. Month; Day, Year			
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>9/1960</b> to <b>Feb 9, 1963</b> and last saw him alive on <b>Feb 9, 1963</b> Death occurred at <b>9/30</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE <i>Mo. Lutenalun D.</i>		(Degree or title)	22b. ADDRESS <b>Kirksville Mo</b>
22c. DATE SIGNED <b>2-11-63</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Feb. 11/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Queen City</b>	23d. LOCATION (City, town, or county) (State) <b>Queen City, Schuyler, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Foster Memorial Home, Kirksville, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>Feb 11, 1963</b>	26. REGISTRAR'S SIGNATURE <i>Doris W. Ratliff</i>

USE BLACK INK OR TYPEWRITER RIBBON

M. T. GUTENSOHN, D.O.

Not permitted to be used

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   
Nova E. Foster

Licensed Embalmer No. 4742  
P. O. Address Kirksville, 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.