

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8942

State File No. _____

FILED MAR 18 1946

Registration District No. 99

Primary Registration District No. 5380

Registrar's No. 15

32

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

17871

1. PLACE OF DEATH:

(a) County De Kalb

(b) City or town Clarksdale, RURAL
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 20 YEARS years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County De Kalb

(c) City or town STEWARTSVILLE - RURAL
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Homer Ellis

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years (Day) (Year)

7. Birth date of deceased December 29 1895
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

60 1 23 hr. min.

9. Birthplace FALL CITY NEBRASKA
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business _____

MOTHER FATHER { 12. Name WILLIAM ELLIS

13. Birthplace MISSOURI
(City, town, or county) (State or foreign country)

14. Maiden name SARAH ELLIS

15. Birthplace FALL CITY NEBRASKA
(City, town, or county) (State or foreign country)

16. (a) Informant W. H. ELLIS

(b) Address STEWARTSVILLE, Mo.

17. (a) BURIAL (b) Date thereof FEB. 23 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CLARKSDALE CEMETERY

18. (a) Signature of funeral director _____

(b) Address Stewartsville Mo.

19. (a) 2-21-46 (b) Roscoe Davidson
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 22 year 1946 hour 2:00 minute A M.

21. I hereby certify that I attended the deceased from Feb 21 1946 to Feb 22 1946
that I last saw him alive on Feb 21 1946
and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Edema Duration 8 hrs.

Due to Myocarditis.

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy 932

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____
While at work _____ (e) Means of injury _____

23. Signature Dr. O. P. ... (M. D. or other) Dr.
Address Stewartsville Mo. Date signed 2-23-46

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed J. G. Lyon

Licensed Embalmer No. 952

P. O. Address Stewartsville, 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 this body is not embalmed, fact should be so stated above.