WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

33280

PLACE OF DEATH

County: Polk

Township: Johnson

or Village:

or City: Humansville NO. ____ St.: ____ Ward)

Registration District No. 703 File No. 10

Primary Registration District No. 5932 Registered No. ____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Abraham Ellis

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED, WIDOWED OR DIVORCED (Write the word)
M	W	married

DATE OF BIRTH: Jan (Month) 29 (Day), 1842 (Year)

AGE: 79 yrs. 10 mos. 11 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): —

BIRTHPLACE (City or town, State or foreign country): Ohio

PARENTS
- NAME OF FATHER: Wm B. Ellis
- BIRTHPLACE OF FATHER (City or town, State or foreign country): Ohio
- MAIDEN NAME OF MOTHER: Unknown
- BIRTHPLACE OF MOTHER (City or town, State or foreign country): Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. A. Joseph

(ADDRESS) Humansville Mo

Filed Dec. 10, 1921, Helen Beaty REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Dec (Month) 10 (Day), 1921 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 6, 1921, to Dec 10, 1921, that I last saw him alive on Dec 10, 1921, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Labor Pneumonia

(Duration) ___ yrs. ___ mos. 4 ds.

Contributory (Secondary) ___

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) [illegible] M. D.

12-13, 1921 (Address) Humansville Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? ___

Former or usual residence ___

PLACE OF BURIAL OR REMOVAL: Humansville Mo

DATE OF BURIAL: 12-13, 1921

UNDERTAKER: J. A. Joseph

ADDRESS: Humansville Mo

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., *1*.....
(Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or ....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., *191*.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....; that I last saw h..... alive on ....., 191.....; and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory .....
(SECONDARY)

.....(Duration).....yrs. .....mos. .....ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191.....
UNDERTAKER	**ADDRESS**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.