

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

Do not use this space.

1815

1. PLACE OF DEATH

County Jackson
 Township Kaw
 City Kansas City

Registration District No. 399
 Primary Registration District No. 1002

File No. _____
 Registered No. 407
 St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 5511 The Paces St. 15 Ward.
 (Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Cora Ellis

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-19-1886

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
42 5 6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Office manager
 (b) General nature of industry, business, or establishment in which employed (or employer) Bookkeeper
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Thomas A. Ellis

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Tenn.

12. MAIDEN NAME OF MOTHER Martha Winger

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Missouri

14. INFORMANT James R. Ellis
 (Address) West Plains Mo.

15. FILED 1-27-29 M. M. Crowe
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 25 1929

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at 9:45 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Suicide, fire arm
 167
 170
 (duration) yrs. mos. da.
 CONTRIBUTORY (SECONDARY) _____
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS History of infection
 (Signed) Stanley M. Hall, M. D.

125, 1929 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Int. Mariah Cemetery 1/28 1929

20. UNDERTAKER ADDRESS 3235

Stine & McClure 4 C. Gilham

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.

