

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

Do not use this space.

35170

**1. PLACE OF DEATH**

County.....  
Township.....  
City.....

Registration District No. 791  
Primary Registration District No. 1003

File No.....  
Registered No. 9903  
St..... Ward)

**2. FULL NAME**

Ellen Partis  
(a) Residence. No. 1921 N. Franklin, 21 Ward.  
(Usual place of abode)

(Booked & filed)  
(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 29 - 1892

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
36 11 14

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work House Work  
(b) General nature of industry, business, or establishment in which employed (or employer) at home  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)  
Miss

10. NAME OF FATHER William McCree

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

12. MAIDEN NAME OF MOTHER Susan Combes

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

14. INFORMANT Duke Partis  
(Address) 1921 N. Franklin Ave

15. FILED Oct - 8, 1929 May C. Starkloff  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/3 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 Oct 3 1929 that I last saw her alive on Oct 3, 1929, and that death occurred, on the date stated above, at, 7 P. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Pneumonia  
109A  
56E

(duration) yrs. mos. ds.  
CONTRIBUTORY Weakened Rheumatic Condition  
(SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED?  
101 W. Schouie  
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF Oct

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical examination  
(Signed) Oral S. McClellan, M. D.

(Address) 1046 N. Sarah

\*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 Booker Washington DATE OF BURIAL 10-9 1929

20. UNDERTAKER P. M. Green ADDRESS 3517 Laclade Ave

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.

WRITE FULLY, WITH OUTSTANDING INK—THIS IS A PERMANENT RECORD

235  
2

