

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

Do not use this space.

18937

1. PLACE OF DEATH

County Platte
Township Pitts
City Parkville (No. 11) (Ward)

Registration District No. 695
Primary Registration District No. 4417

File No. 622
Registered No. 11

2. FULL NAME

Ralph Leonard McElhinney (McElhinney)

(a) Residence No. 11 St. Ward (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

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 Marie McElhinney Reddoch

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 15 - 1895

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
<u>35</u>	<u>8</u>	<u>19</u>		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Salesman 1920
(b) General nature of industry, business, or establishment in which employed (or employer) Hardware
(c) Name of employer R B Elliott

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Morning Sun Iowa

10. NAME OF FATHER W R McElhinney

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) no knowledge

12. MAIDEN NAME OF MOTHER Anna May Elliott

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) no knowledge

14. INFORMANT (Address) Mrs R B Elliott Parkville Mo

15. FILED 5/6 1931 J D Winder REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 4 1931

17. I HEREBY CERTIFY, That I attended deceased from May 4, 1931, to May 4, 1931, that I last saw him alive on May 4, 1931, and that death occurred, on the date stated above, at 9 PM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Indigestion
11 00 (duration) 1 hr yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS none
(Signed) J. Underwood, M. D.
, 19 (Address)

*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 Morning Sun Iowa DATE OF BURIAL May 7 1931

20. UNDERTAKER Noland Undertaking Co ADDRESS Parkville, Mo

MAY 27 1931

PARENTS

MAY 22 1957

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Platte
Township Barboursville
City Barboursville (No.) St. Ward)

Registration District No. 695
Primary Registration District No. 4417

File No. 627
Registered No. 11

2. FULL NAME

Ralph S. McElhinney

(a) Residence. No. St. 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

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

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED 19..... J. Williams REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 4 19 31

17. I HEREBY CERTIFY That I attended deceased from 19....., 19..... that I last saw h. alive on 19....., and that death occurred, on the date stated above, at

THE CAUSE OF DEATH WAS AS FOLLOWS: acute indigestion
overload + excumbia
(duration) yrs. mos. ds.

CONTIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D. , 19 (Address)

*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 19

20. UNDERTAKER ADDRESS

PARENTS

SUPPLEMENTARY

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