

REC'D OCT 5 1938

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

33585

Do not use this space.

1. PLACE OF DEATH

(a) County Worth Registration District No. 903
 (b) Township Wentworth Primary Registration District No. 545 Registered No.
 (c) City Grant City, Mo. (d) Street No. (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

PATRICIA ANN ELLIOTT
 (a) Residence, No. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, 3 hrs. or 3 min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Infant
 9. Industry or business in which work was done, as saw mill, bank, etc. Infant
 10. Date deceased last worked at this occupation (month and year) Infant 11. Total time (years) spent in this occupation Infant

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Grant City Mo

FATHER 13. NAME Wayne Elliott
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jefferson Mo

MOTHER 15. MAIDEN NAME Mildred Sparks
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Griffin Iowa

17. INFORMANT (ADDRESS) Wayne Elliott Grant City Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Grant City Mo. 9/20/38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) A. C. Dumble Grant City Mo.20. FILED 10-7-38 Frank Mull M.P. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 20, 193822. I HEREBY CERTIFY, That I attended deceased from Sept 16, 1938, to Sept 20, 1938

I last saw her alive on Sept 20, 1938 Death is said to have occurred on the date stated above, at 3:00 a. m.

The principal cause of death and related causes of importance were as follows:

Granular baby
Seven months old
(or younger)
lived about 3 hours

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Physiologically Was there an autopsy? No23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury ✓, 19.....Where did injury occur? ✓ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury ✓Nature of injury ✓24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) B. W. Russell M. D.(Address) Grant City 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,

Arch C Duffee

....., or by

Registered Apprentice No., working under my personal supervision.

Signed

Arch C Duffee

Licensed Embalmer No. *3252*

P. O. Address *Grant City, 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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

335-82-
Do not use this space.

1. PLACE OF DEATH *North*
 (a) County..... Registration District No. *903*
 (b) Township..... Primary Registration District No. *45-45-*
 (c) City..... (d) Street No. Registered No.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Patricia Ann Elliot*
 (a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *7* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *Inf*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Sept. 19 1938*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, *3* hrs. or *3* min.

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

FATHER
 13. NAME
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
 15. MAIDEN NAME
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)
 18. BURIAL, CREMATION, OR REMOVAL PLACE DATE
 19. FUNERAL DIRECTOR (ADDRESS)
 20. FILED *10-4* 19*38* *Paul Mull M.D.* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

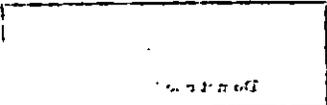
21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept 20 1938*
 22. I HEREBY CERTIFY, That I attended deceased from
 I last saw him alive on, 19..... Death is said to have occurred on the date stated above, at.....m.
 The principal cause of death and related causes of importance were as follows:
 Date of onset
 Other contributory causes of importance:
 Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy?.....
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury.....
 Nature of injury.....
 24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify..... (Signed) *C. J. Rosely* M. D.
 (Address) *Wentz City Mo*

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

DEATH IN PLAIN TERMS, SO THAT IT IS PROPERLY CLASSIFIED.

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



1. PLACE OF DEATH

(a) County _____ Registration District No. _____
 (b) Township _____ Precinct Registration District No. _____
 (c) City _____ Street No. _____
 (d) Death occurred in _____ (If death occurred in H. Hospital or Institution)
 (e) Length of residence in city or town where death occurred _____ yrs. mos. da. (f) How long

2. PRINT FULL NAME

(a) Residence, No. _____
 (b) Usual place of abode, if no other address, give county or

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, DIVORCED (etc.)
6. DATE OF BIRTH (MONTH, DAY, YEAR)	7. AGE (YEARS)	8. IF MARRIED, WIDOWED, OR DIVORCED (OR WIFE OR HUSBAND OF)

S-33585

NOTE

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS