

MAY 18 1939

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

15263
Do not use this space.

1. PLACE OF DEATH

(a) County Johnson Registration District No. 437
(b) Township Rosehill Primary Registration District No. 5594
(c) City Latour (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

440 John Robert Elwell
(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 Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Dora Hansbrough Elwell		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 21, 1875		
7. AGE 63	YEARS 8	MONTHS 8
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Truckman		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
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Andersville Indiana		
13. NAME Albert Elwell		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown Indiana		
15. MAIDEN NAME Sarah J. Allen		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown unknown		
17. INFORMANT Mildred Elwell (ADDRESS) Latour, Missouri		
18. BURIAL, CREMATION, OR REMOVAL PLACE Knobnoster, Mo. DATE Jan. 30-1939		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Huston-Turner Windsor, Mo.		
20. FILED Jan 22, 1939 Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **January 29, 1939**

22. I HEREBY CERTIFY, That I attended deceased from **June 28, 1938** to **Jan 29, 1939**.
I last saw him alive on **Jan 28, 1939**. Death is said to have occurred on the date stated above, at **4 a.m.**
The principal cause of death and related causes of importance were as follows:

Bronchial PneumoniaDate of onset
1-23-39

Other contributory causes of importance:

Chronic Prostatitis
Chronic infectious Arthritis

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? **no**

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? **no**
If so, specify _____
(Signed) **Kelly Rowland**, M. D.

(Address) **Holden, Mo.**
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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.

RECEIVED
DISTRICT HEALTH OFFICER NO. 8
DISTRICT FILE NUMBER
DATE FILED

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DISTRICT HEALTH OFFICER NO. 8
DISTRICT FILE NUMBER
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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, or by.....

Ellis M. Huston

....., Registered Apprentice No.....

working under my personal supervision.

Signed *Ellis M. Huston*

Licensed Embalmer No. *3391*

P. O. Address *Windsor 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.

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15263
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1. PLACE OF DEATH

(a) County Johnson Registration District No. 437
(b) Township Roschell Primary Registration District No. 5294
(c) City (d) Street No. St.
(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

John Robert Ellwell
(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wed

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

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

7. AGE YEARS 63 MONTHS 8 DAYS 8 If LESS than 1 day, hrs. or min.

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

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19.....

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED April 2 1939 Anna Coleman Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-29 1939

22. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....

I last saw h..... 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) Kelley Rawlins, M. D.

(Address) Hadden mo

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

SUPPLEMENTARY

