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.

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

REC'D JUL 6 1939

21916
Do not use this space.

1. PLACE OF DEATH
(a) County Cole — Registration District No. 211
(b) Township Marion — Primary Registration District No. 5291 — Registered No. 6
(c) or City ~~Jefferson~~ Elston — (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 Isabelle Elston
(a) Residence, No. Elston, Mo 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: Female
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: Don A. Elston
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): May-12-1898
7. AGE: YEARS 41 — MONTHS 1 — DAYS 16 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Housewife
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): Salina, Kanaas

FATHER
13. NAME: James Shanks
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Strafford, Mo

MOTHER
15. MAIDEN NAME: Marian Brand
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Scotland

17. INFORMANT (ADDRESS): Don A. Elston, Elston, Missouri
18. BURIAL, CREMATION, OR REMOVAL
PLACE: Elston, Mo DATE: June-30-1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS): Shorey J. Gordon, Jefferson City, Mo
20. FILED: June 30 1939 H. T. Beach M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): June 28, 1939
22. I HEREBY CERTIFY, That I attended deceased from May 1, 1939, to June 28, 1939
I last saw her alive on June 28, 1939. Death is said to have occurred on the date stated above, at 11 A m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
9 1/2	May 1 or 1939
Cerebral Thrombosis	

Other contributory causes of importance:
Bacterial Endocarditis

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) M R Aldridge, M. D.
(Address) .....

(Licensed Embalmer's Statement on Reverse Side)

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 Ferd P Dulle, Registered Apprentice No. ..... working under my personal supervision.

Signed Ferd P Dulle

Licensed Embalmer No. 3890

P. O. Address Jefferson City Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.