

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.

RECORDED DEC 21 1939

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

39078  
 Do not use this space.

1. PLACE OF DEATH 3  
 (a) County Buchanan Registration District No. 85  
 (b) Township 1 Primary Registration District No. 1001 Registered No. 1212  
 (c) City St. Joseph Mo. (d) Street No. Hospital # 2 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. 2 mos. 23 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Geo. Cowan McElroy  
 (a) Residence, No. State Hospital # 2 St.  Ravenwood Mo.  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>wid.</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Mary Lawson McElroy</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Dec. 13, 1856</u>		
7. AGE YEARS <u>82</u>	MONTHS <u>11</u>	DAYS <u>11</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>farmer</u>		If LESS than 1 day, ..... hrs. or ..... min.
9. Industry or business in which work was done, as saw mill, bank, etc.		11. Total time (years) spent in this occupation
10. Date deceased last worked at this occupation (month and year)		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Lee Co. Va.</u>		
13. NAME		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>no information available</u>		
15. MAIDEN NAME		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>no information available</u>		
17. INFORMANT (ADDRESS) <u>Mrs. Lucy Rhodes, Ravenwood, Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Ravenwood, Mo.</u> DATE <u>11/26, 1939</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Lang &amp; Bond, Ravenwood, Mo.</u>		
20. FILED <u>11/29/39</u> , 19 <u>39</u> Local Registrar <u>85</u>		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 24, 1939  
 22. I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1939, to Nov. 24, 1939  
 I last saw him alive on 11, 1939. Death is said to have occurred on the date stated above, at 11:20 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Arteriosclerosis  
fracture of l. femur - Nov. 4/39  
broncho-pneumonia  
 Name of operation none Date of 11/11/39  
 What test confirmed diagnosis? clinical Was there an autopsy? no  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? no Date of injury 11/4, 1939  
 Where did injury occur? W. Va. - State Hospital # 2 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury fell from bed  
 Nature of injury fracture of l. femur at neck  
 24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify \_\_\_\_\_  
 (Signed) T. J. G. Bell, M. D.  
 (Address) St. Joseph, Mo.

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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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.**