

11 1939

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

43968  
Do not use this space.

1. PLACE OF DEATH

(a) County Madison Registration District No. 538  
(b) Township St. Michael Primary Registration District No. 3028 Registered No. 76  
(c) City Fredericktown (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

(a) Residence, No. 502 East 5th St. St. 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) \_\_\_\_\_  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lorel O. Ellison  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_  
7. AGE YEARS 77 MONTHS 7 DAYS 16 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
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) Madison Mo

13. NAME Alexander Ellison

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

15. MAIDEN NAME Eliza Jane DeShu

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

17. INFORMANT Datta Ellison (ADDRESS) St Louis Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Christians Cemetery DATE Dec 10 - 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Chas. H. Webb

20. FILED Dec 8 1939 S. G. S. Daugherty Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 7 - 1939

22. I HEREBY CERTIFY, That I attended deceased from Dec 1 - 1939 to Dec 7 - 1939  
I last saw him alive on Dec 6th - 1939 Death is said to have occurred on the date stated above, at 12:50 AM  
The principal cause of death and related causes of importance were as follows:

Hepatitis followed by Capillary Bronchitis Date of onset 11-29

Other contributory causes of importance: 1256

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) M. B. Parker M. D.  
(Address) Fredericktown Mo

WRITE PLAINLY, WITH UNFADING INK. THIS IS VERY IMPORTANT. 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.

I X14008

STATE OF MISSISSIPPI  
DEPARTMENT OF HEALTH  
BUREAU OF HEALTH SERVICES

STATE NO. 2000-111

DATE OF DEATH

AGE

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BURIAL

SEX

EDUCATION

RELATIONSHIP TO DECEASED

DATE OF STATEMENT

**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,

*Ed. H. Webb*

, or by

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

Signed

*Ed. H. Webb*

Licensed Embalmer No.

731

P. O. Address

*Ed. H. Webb*

**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

43968 Do not use this space.

1. PLACE OF DEATH (a) County Madison (b) Township Fredericctown (c) City Fredericctown (d) Street No. (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 (a) Residence, No. (Usual place of abode, if no street address, write county or city) 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) wid 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr-22-1862 7. AGE YEARS 77 MONTHS 7 DAYS 76 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. FUNERAL DIRECTOR (ADDRESS) 20. FILED Jul 6 - 1916 S. C. S. Langley Local Registrar. By G. A. Schranz

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 7, 1939 22. I HEREBY CERTIFY, That I attended deceased from 19... to 19... 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) M. B. Barber M. D. (Address) Fredericctown Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHISTONIANS should state occupation so that it can be carefully supplied. AGE should be filled EXACTLY. PHISTONIANS should state

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

TO : SAC, NEW YORK (100-100000)

FROM : SAC, PHOENIX (100-100000)

SUBJECT: [Illegible]

Re Phoenix teletype to New York dated 1/15/68.

Enclosed for New York are two copies of a letterhead memorandum dated 1/15/68.

The letterhead memorandum contains information regarding the activities of [Illegible] in Phoenix, Arizona.

Very truly yours,  
[Illegible Signature]

Special Agent in Charge

Enclosure

100-100000-1000

100-100000-1000

100-100000-1000

100-100000-1000

100-100000-1000