DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7660

Registration District No. [illegible]

Primary Registration District No. [illegible]

Registrar's No.

1. PLACE OF DEATH:

(a) County Pemiscot Lith.

(b) City or town Rural Wardell
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pemiscot

(c) City or town Rural Wardell
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) If foreign born, how long in U. S. A.? — years.

3. (a) PRINT FULL NAME Jossie Ellison 425

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Female

5. Color or race Black

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Lewis Ellison

6. (c) Age of husband or wife if alive dead years

7. Birth date of deceased Oct (Month) 10 (Day) 1859 (Year)

8. AGE: Years 80 Months 5 Days 4 If less than one day hr. min.

9. Birthplace Murphysboro, Tenn. (City, town, or county) (State or foreign country)

10. Usual occupation Farm Worker

11. Industry or business Farm

FATHER
12. Name John Wesley Huff
13. Birthplace Maryland (City, town, or county) Tenn (State or foreign country)

MOTHER
14. Maiden name May Eliza
15. Birthplace (City, town, or county) Tennessee (State or foreign country)

16. (a) Informant's own signature Lillie Mc Brown
(b) Address Wardell, Mo.

17. (a) Bur (Burial, cremation, or removal) (b) Date thereof 3-17-40 (Month) (Day) (Year)
(c) Place: burial or cremation Wardell Mo

18. (a) Signature of funeral director Hill Bros.
(b) Address Lilbourn Mo.

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 14 year 40 hour 6 minute 55 P. M.

21. I hereby certify that I attended the deceased from 3-4, 1940, to 3-14, 1940; that I last saw her alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Terminal Pneumonia	5 days.
Due to Malnutrition & Cachexia	
Due to Partial Paralysis & Dementia	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) —

(b) Date of occurrence —

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? — (Specify type of place)

5 While at work? — (e) Means of injury —

23. Signature R. A. Burnsbrough (M. D. or other)

Address Wardell, Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Rev. 6-17-39 I X19311

109

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.

No. 2B
2-21-40
J X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7660

Registration District No. 1099 Primary Registration District No. 5868 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Pemiscot
(b) ~~City or town~~ Little River Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Vossie Ellison
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex 7
5. Color or race B
6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 80 Months 5 Days 4 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 14
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.
Immediate cause of death Bronchial Terminal Pneumonia
Due to Malnutrition, Cachexia Cachexia
Due to Partial Paralysis + Dementia bulbar type (Parkinsonism)
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy 81

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury
23. Signature R. A. Bussabarger (M.D. or other)
Address Wardell Mo. Date signed

No. 2B
2-21-40
X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7660

Registration District No. 1099 Primary Registration District No. 5868 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Pemiscot

(b) City or town Little River Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits write "RURAL")

(d) Street No.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Vassie Ellison

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex 7

5. Color or race B.

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 80 Months 5 Days 4 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 5-1-40 (Date received local registrar) (b) J. L. Creasy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 14 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)

While at work? (e) Means of injury

23. Signature R. A. Bussabarger (M. D. or other)

Address Wardell Date signed