

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

8402
Do not use this space.

1. PLACE OF DEATH
 (a) County Sullivan Registration District No. 849
 (b) Township Buchanan Primary Registration District No. 6123 Registered No. 4
 (c) City _____ (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. (0) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Jessie Young Ellis
 (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)
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Margaret Ellis
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11-11-1860
 7. AGE YEARS 79 MONTHS 2 DAYS 20 If LESS than 1 day,hrs. ormin.
 8. Trade, profession, or particular kind of work done, as sawyer, bookbinder, etc. Retired 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) Mo. O

FATHER 13. NAME Willias Ellis
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown, Mo.

MOTHER 15. MAIDEN NAME Emmie Young
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown, Mo.

17. INFORMANT (ADDRESS) Fred Wolf Green City

18. BURIAL, CREMATION, OR REMOVAL PLACE Parson DATE Feb 2 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) F. O. Husted & Co. Unionville Mo.

20. FILED Feb 29 1940 Virginia Gibson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-1 . 19 40

22. I HEREBY CERTIFY, That I attended deceased from Jan 23, 1940, to Feb 1, 1940.
 I last saw him alive on Jan 23, 1940. Death is said to have occurred on the date stated above, at 10:30 AM.

The principal cause of death and related causes of importance were as follows:

The result of a fall he received about 3 months ago and was hurt intensely

Date of onset

Other contributory causes of importance: 156

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? accident Date of injury Jan 23 1940
 Where did injury occur? Oklahoma (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. in the home
 Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No.
 If so, specify _____
 (Signed) W. H. Houghton MD, M. D.
 (Address) Green City Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

RECEIVED

District Health Officer No. 10

District File Number 3-40-538

Date Filed MAR 1 1940

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **8409**

Registration District No. **849**

Primary Registration District No. **6123**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Sullivan

(b) City or town Suchanan
(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 _____ (Specify whether _____)

3. (a) PRINT FULL NAME Jimmie Jung Ellis

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M **5. Color or race** W

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

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	Months	Days	If less than one day
<u>79</u>	<u>2</u>	<u>20</u>	_____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ **(b) Date thereof** _____ (Month) _____ (Day) _____ (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Feb-29-1940 **(b)** Virginia Gibson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Sullivan

(c) City or town Green City
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 2 day 1
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 _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) _____ (Means of injury)

23. Signature W. H. Kington (M. D. or other) _____

Address Green City Date signed Feb

SUPPLEMENTAL

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

