FILED MAR 7 - 1940

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

8557
Do not use this space.

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.

1. PLACE OF DEATH
(a) County Worth — Registration District No. 623
(b) Township Allendale — Primary Registration District No. 4545 — Registered No.
or (c) City Grant City, Mo. (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 6 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME HATTIE MAE ELLIOTT
(a) Residence, No. Worth County St.
(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 F — 4. COLOR OR RACE W — 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Harry Elliott

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 18, 1871

7. AGE — YEARS 68 — MONTHS 7 — DAYS 22 — 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) Oct. 1938
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Grant City, Mo.

FATHER
13. NAME Elihugh Rowan
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cincinatti, Ohio

MOTHER
15. MAIDEN NAME Sinthy Hatley
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT Harry Elliott
(ADDRESS) Grant City, Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Grant City Cem. DATE 2/13 1940

19. FUNERAL DIRECTOR (NAME) A. C. Dunfee
(ADDRESS) Grant City, Mo.

20. FILED ......19...... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-10- 1940

22. I HEREBY CERTIFY, That I attended deceased from 6-1- 1935 to 2-10- 1940
I last saw her alive on 2-10- 1940. 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
Influenza — 2-2-40

Other contributory causes of importance:
Tuberculosis of lungs — 1935

Name of operation none — Date of...
What test confirmed diagnosis? Physical findings — 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) C. J. Fraser MD, M. D.
(Address) Grant City, Mo.

(Licensed Embalmer's Statement on Reverse Side)

I X16605

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 Jack C. Dunfee

Licensed Embalmer No. 3252

P. O. Address Grant City, Mo

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
1—2-21-40
X22659

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 85-57

Registration District No. 903 Primary Registration District No. 45-45 Registrar's No.

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

1. PLACE OF DEATH
(a) County Worth
(b) City or town Grant City
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Worth
(c) City or town Grant 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.

3. (a) PRINT FULL NAME Hattie Mae Elliot
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex 7
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or ~~wife~~ Harry Elliott
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 68 Months 7 Days 12 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

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

FATHER
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) April 22 (Date received local registrar) (b) Clifford Hass (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 10
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 P. J. Rose (M. D. or other)
Address Grant City Date signed

SUPPLEMENTARY