

N. E.—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.

17
3
1

MAY 13 1940

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

14541
Do not use this space.

1. PLACE OF DEATH
 (a) County Carroll Registration District No. 135
 (b) Township 2 Primary Registration District No. 3010 Registered No. 50
 (c) City Carrollton or (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 Allie Irene Elliott
 (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 Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 27, 1901

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
39 0 25

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. social
 9. Industry or business in which work was done, as saw mill, bank, etc. Welfare Work
 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) Carroll Co. Mo.

FATHER
 13. NAME Jacob Falke
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Carroll Co. Mo.

MOTHER
 15. MAIDEN NAME Susan Stanford
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Carroll Co. Mo.

17. INFORMANT (ADDRESS) Chas. Henry Elliott
Carrollton Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Starbuck Co. DATE Apr 23, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Stanley
Carrollton Mo.

20. FILED 4-23, 1940 With Haskins
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr. 21, 1940

22. I HEREBY CERTIFY, That I attended deceased from Jan. 1939, to April 21, 1940
 I last saw her alive on April 21, 1940 Death is said to have occurred on the date stated above, at 8:00 p.m.
 The principal cause of death and related causes of importance were as follows:
Myocardial Infarction -
7 2 1/2
 Other contributory causes of importance: Emphysema
Nov 1939

Date of onset Dec. 1939

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? No
 If so, specify _____
 (Signed) Charles S. Cassette, M. D.
 130 (Address) Carrollton Mo.

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 5-10-40

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 Ben W. Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton, Md.

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.