

OCT 23 1940  
Registration District No. 1

Primary Registration District No. 1

Registrar's No. 221

1. PLACE OF DEATH:

(a) County Adair  
(b) City or town Kirkville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Grim-Smith Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution one day  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County KNOX  
(c) City or town RURAL  
(If outside city or town limits, write "RURAL")  
(d) Street No. COLONY  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Elizabeth Minnie Ammons

8. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband Millard J. Ammons 6. (c) Age of husband or wife 60 years

7. Birth date of deceased May 1, 1884  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
56 4 20 hr. min.

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

10. Usual occupation House wife

11. Industry or business Domestic

12. Name Bernhard Tonnies

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

14. Maiden name Albertina Westfall

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

16. (a) Informant M. J. Ammons

(b) Address Rutledge, Mo.

17. (a) Burial (b) Date thereof Sept. 23/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Colony Cemetery

18. (a) Signature of funeral director Davis Funeral Home

(b) Address Kirkville, Mo.

19. (a) Sept. 23/40 (b) Spencer L. Freeman  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 21  
year 1940 hour 10 minute 50 P M.

21. I hereby certify that I attended the deceased from Sept 21, 1940 to Sept 21, 1940

that I last saw her alive on Sept 21, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Cholerae typhoides and hepatitis

Duration 2 wks?

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death)

Major findings: Gall Bladder Operation July 4, 1940 at Ruth's Shop  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Arthur Beardsley (M. D. or other) \_\_\_\_\_

Address Rutledge Mo Date signed 9-23-40

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

MOTHER FATHER

125-82  
[AUG 16 1940]

AUG 16 1940

RECEIVED

District Health Officer No. 10

District File Number 10-46-1999

Date Filed OCT 24 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 *Harold N. Wigan*

Licensed Embalmer No. 4076

P. O. Address *Trickville,*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HAND WRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

2B  
1-40  
22859

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **31241**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **1**

Primary Registration District No. **1**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **Adair**  
(b) City or town **Fiskville mo**  
(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)

3. (a) PRINT FULL NAME

**Elizabeth Minnie Rumors**

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 **m**

6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

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

8. AGE: Years **53** Months **4** Days **20**  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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)

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

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

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

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **21**  
year **1900** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death **Cholelithiasis and Hepatitis**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

**Gall bladder operation, 2 hrs operated upon at about 7 o'clock. Had operation hood**

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

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence **flax previous with stone found**  
(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) (r) Means of injury \_\_\_\_\_

23. Signature **C. B. ...** (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTAL

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

