o. 2
13-40
7-39
X23159

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. 31568

FILED OCT 12 1940

Registration District No. 104 — Primary Registration District No. 3008 — Registrar's No. 247

1. PLACE OF DEATH:
(a) County: Callaway
(b) City or town: Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital #1, - Fulton, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 19 days 3 (Specify whether
In this community: years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Saline
(c) City or town: Slater
(If outside city or town limits, write "RURAL")
(d) Street No.: None
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Elfleata Hisle
3. (b) If veteran, name war: ____
3. (c) Social Security No. none
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: James E Hisle
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: Nov. (Month) 6 (Day) 1888 (Year)

8. AGE: Years	Months	Days	If less than one day
51	10	12	____ hr. ____ min.

9. Birthplace: DK (City, town, or county) MO (State or foreign country) 0
10. Usual occupation: Housewife
11. Industry or business: Home
MOTHER FATHER
12. Name: Henry Yowell
13. Birthplace: DK (City, town, or county) Virginia (State or foreign country)
14. Maiden name: Laura Thomas
15. Birthplace: DK (City, town, or county) Virginia (State or foreign country)
16. (a) Informant: State Hospital #1, Records
(b) Address: Fulton Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-19-'40 (Month) (Day) (Year)
(c) Place: burial or ~~cremation~~: Slater Mo
18. (a) Signature of funeral director: Hill Brothers
(b) Address: Slater - Mo
19. (a) 9/18/40 (Date received local registrar) (b) R. N. Crews (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 18 year 1940 hour 11 minute 30 P. M.
21. I hereby certify that I attended the deceased from Aug 28, 1940 to Sept. 18, 1940 that I last saw him alive on Sept. 18, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchopneumonia	1 week
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death): Secondary Hypochromic Anemia	

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? ____
While at work? ____ (Specify type of place) (e) Means of injury: ____

23. Signature: Forest Thomas (M. D. ~~or other~~)
Address: State Hospital No 1 - Date signed: ____

(Licensed Embalmer's Statement on Reverse Side)

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 w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.