

DEC 16 1940
Registration District No. 777 190

Primary Registration District No. 200

Registrar's No. 74

1. PLACE OF DEATH:

(a) County CLARK
(b) City or town ST. PATRICK RURAL
(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 YEAR 9 (Specify whether years, months or days) 2

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County CLARK
(c) City or town NEAR ST. PATRICK
(If outside city or town limits, write "RURAL")
(d) Street No. NEAR STATICK
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

3. (a) PRINT FULL NAME NORA GANE ELLISON

3. (b) If veteran, name war None 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 FRANK ELLISON 6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased MAR 4 1869
(Month) (Day) (Year)

8. AGE: Years 76 Months 9 Days 29 If less than one day hr. min.

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

10. Usual occupation HOUSE WIFE

11. Industry or business FARMING

12. Name ADAM NAHM

13. Birthplace GERMANY

14. Maiden name AMANDA TRAYAN

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

16. (a) Informant's own signature Frank Ellison

(b) Address Carleton MO

17. (a) BURIAL (b) Date thereof 12-3-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ELLISON CEM

18. (a) Signature of funeral director F. D. Kelly

(b) Address Carleton MO

19. (a) Dec. 5, 1940 (b) A. W. Jennings
(Date received local registrar) (Registrar's signature)

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 3rd year 1940 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from Dec. 3, 1940 to Dec 3, 1940 that I last saw her alive on Dec 3, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Shock due to Burns Duration 6 hrs.

Due to 3rd degree burn of body

Due to _____

Other conditions (Include pregnancy within 3 months of death) 181

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) Accident

(b) Date of occurrence Dec 4 - 1940

(c) Where did injury occur? Near St. Patrick Clark Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work? yes (Specify type of place) (a) Means of injury Burn

23. Signature A. W. Jennings (M. D. or other) MD

Address Carleton MO Date signed 12-5-40

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 12-40-2295-

Date Filed DEC 13 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.....

M. S. Kelly

Registered Apprentice No. 1965

working under my personal supervision.

Signed.....

M. S. Kelly

Licensed Embalmer No. 1965

P. O. Address..... *Canton, 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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

38459
Do not use this space.

1. PLACE OF DEATH
 (a) County Clark Registration District No. 190
 (b) Township Jackson Primary Registration District No. 5274 Registered No. _____
 (c) City _____ (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 Nora Jane Ellison
 (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>76</u>	<u>9</u>	<u>21</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 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) Missouri

FATHER
 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER
 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____
 18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19 _____

19. FUNERAL DIRECTOR (ADDRESS) _____
6/4 1941 J. R. Bridges
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 4 1940

22. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19____.

I last saw h. _____ alive on _____, 19____. 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: _____

Other contributory causes of importance: _____

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? _____
 If so, specify _____
 (Signed) S. J. Hillard _____ M. D.
 (Address) Carrollton _____

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

