

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

41690

State File No. \_\_\_\_\_

Registration District No. 2

Primary Registration District No. 205

Registrar's No. 49

1. PLACE OF DEATH:

(a) County Andrew  
(b) City or town Savannah  
(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 66yrs

8. (a) PRINT FULL NAME Ella Teresa Townsend

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife E. E. Townsend 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 5 28 1873  
(Month) (Day) (Year)

8. AGE: Years 67 Months 6 Days 20 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Savannah Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation at Home

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

MOTHER FATHER  
12. Name George W. Selecman 9  
13. Birthplace un known  
(City, town, or county) (State or foreign country)  
14. Maiden name Sarah Jane Murphy  
15. Birthplace un known  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Warren Townsend

(b) Address Savannah Mo.

17. (a) B. (b) Date thereof 12 20 40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Savannah

18. (a) Signature of funeral director E. C. Breit

(b) Address Savannah Mo.

19. (a) Dec 20 40 (b) Mrs. Jennie Rash  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew  
(c) City or town Savannah Mo  
(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 12 day 18  
year 1940 hour 5 minute 45 P. M.

21. I hereby certify that I attended the deceased from July 16, 1940  
Dec 18, 1940 to Dec 18, 1940  
that I last saw her alive on Dec 18, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Aortic Insufficiency Duration \_\_\_\_\_

Due to Paralysis of both sides 9 yr.

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

Other conditions none  
(Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none

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? 9711  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J. C. Hoshov (M. D. or other) \_\_\_\_\_  
Address Savannah Mo. Date signed 12-20

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.

420

MAY 26 1978

**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 E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Savannah 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 41690

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 2

Primary Registration District No. 205

Registrar's No. 49

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

1. PLACE OF DEATH:

(a) County Andrew  
(b) City or town Sassafras  
(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 Ella Teresa Townsend

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

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced, wid

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

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

8. AGE: Years 67 Months 6 Days 20 If less than one day min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 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) (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) (Date received local registrar) (b) (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 12 day 18 year 1942 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: Asthma Insufficiency  
Due to Paralysis of both sides Bulbar Type

Other conditions (Include pregnancy within 3 months of death) 8/10

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 (M. D. or other) Address Date signed

SUPPLEMENTARY

S-41690 1940