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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1798

Registration District No. 85 Primary Registration District No. 1001 Registrar's No. 27

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

11
1
7

1. PLACE OF DEATH:
(a) County BUCHANAN
(b) City or town ST. JOSEPH
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 9. STATE HOSPITAL No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 18 yrs (Specify whether
In this community 18 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Atchison 11
(c) City or town Watson 1
(If outside city or town limits, write "RURAL")
(d) Street No. 7
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME LAURA ALFRETA ELLISON

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 W 2

6. (b) Name of husband or wife Wm. Miller Ellison
6. (c) Age of husband or wife if alive years

7. Birth date of deceased Dec. (Month) 14 (Day) 1862 (Year)

8. AGE: Years 78 Months 0 Days 24 If less than one day hr. min.

9. Birthplace Owensburg (City, town, or county) Kentucky 1 (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Thomas B. Hudson
13. Birthplace ? (City, town, or county) Kentucky 1 (State or foreign country)

MOTHER
14. Maiden name Amanda Baxter
15. Birthplace Owensburg (City, town, or county) Kentucky 1 (State or foreign country)

16. (a) Informant Hosp. Records
(b) Address State Hosp #2 St Joseph, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 1-10-41 (Month) (Day) (Year)
(c) Place: burial or cremation Watson, Mo.

18. (a) Signature of funeral director FLEEMAN & SON INC.
(b) Address St. Joseph, Mo. 85

19. (a) Jan 9 1941 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 8
year 1941 hour 11 minute 55 A.M.

21. I hereby certify that I attended the deceased from July 1, 1940, to Jan. 8, 1941;
that I last saw her alive on Jan. 8, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis — Duration 7 yrs

Due to

Due to 13 B

Other conditions Manic Depressive Psychosis
(Include pregnancy within 3 months of death)

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 Kenneth Thompson (M. D. ~~[illegible]~~) D
Address State Hosp #2 St Joseph, Mo. Date signed 1-8-41

(Licensed Embalmer's Statement on Reverse Side)

ST. JOSEPH

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 Carl W. Hause

Licensed Embalmer No. 3950

P. O. Address St. Joseph, M

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

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