

Registration District No. 104

Primary Registration District No. 3608

Registrar's No. 69

1. PLACE OF DEATH:

(a) County Calloway
(b) City or town Fulton
(c) Name of hospital or institution: State Hospital no. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 mo - 17 days (Specify whether years, months or days)
In this community 4 mo - 17 days

3. (a) PRINT FULL NAME

William B. Elgin

3. (b) If veteran, name war DK

3. (c) Social Security No. DK

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife DK

6. (c) Age of husband or wife if alive DK years

7. Birth date of deceased Feb 21 1866
(Month) (Day) (Year)

8. AGE: Years 76 Months 0 Days 14 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs Oliver Ray on

(b) Address Naples Mo

17. (a) REMOVAL (b) Date thereof MARCH 5 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MARSHALL MO

18. (a) Signature of funeral director Les Walker

(b) Address Fulton Mo

19. (a) March 5, 41 (b) R. M. Creiva
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dalme
(c) City or town Marshall rural
(If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5 year 1941 hour 10:15 minute 10:15 A.M.

21. I hereby certify that I attended the deceased from Feb 1, 1941, to March 5, 1941; that I last saw her alive on March 5, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to arteriosclerosis

Due to "

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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 Forrest Thomas (M. D. or other)

Address State Hospital No 1 Date signed Fulton Mo

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 with the above constitutes grounds for revocation of license.)

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