

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

Registration District No. 508

Primary Registration District No. 3026

Registrar's No. 63

1. PLACE OF DEATH:

(a) County Linn

(b) City or town Chillicothe
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Chillicothe Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 weeks
(Specify whether years, months or days)

In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn

(c) City or town Chillicothe
(If outside city or town limits, write "RURAL")

(d) Street No. 1206 Jackson St.
(If rural, give location)

(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME Ella Dayton

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Thomas Dayton 6. (c) Age of husband or wife if alive — years

7. Birth date of deceased Feb. 13, 1865
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>1</u>	<u>27</u>	hr. min.

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

10. Usual occupation Housewife

11. Industry or business ✓

12. Name James Rainey

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

14. Maiden name Anderson

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

16. (a) Informant Frank E. Dayton

(b) Address Chillicothe, Mo.

17. (a) Burial (b) Date thereof 7/9/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Catholic Cem.

18. (a) Signature of funeral director James D. Gordon

(b) Address Chillicothe, Mo.

19. (a) 4-8-41 (b) M. H. Kease, M.D.
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7 year 1941 hour 12 minute 40 P. M.

21. I hereby certify that I attended the deceased from March 4, 1941, to April 7, 1941; that I last saw her alive on April 7, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis Duration 14 hrs

Due to

Due to

Other conditions Fractured left hip
(Include pregnancy within 3 months of death)

Major findings: Of operations 1860 Of autopsy 5

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? mi
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 9113
(Specify type of place) While at work? (e) Means of injury

23. Signature P. J. Brennan (M. D. or mi)

Address Chillicothe, Mo. Date signed 7/8/41

1952
NA

EMERALD MOORE

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 Donald J. Gordon

Licensed Embalmer No. 4191

P. O. Address Chillicothe, 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, fact should be so stated above.

Registration District No. 308

Primary Registration District No. 3026

Registrar's No. 63

1. PLACE OF DEATH:

(a) County Lumpkin
(b) City or town Chillicothe
(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

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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Ella Dayton
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

20. DATE OF DEATH Month Apr day 7
year 1941 hour _____ minute _____ M.

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

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.

6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ year
7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

Immediate cause of death Coronary thrombosis *Duration*
Due to _____
Due to _____

8. AGE: Years 76 Months 1 Days 27
If less than one day _____ hr. _____ min.

Other conditions Fractured left hip
(Include pregnancy within 3 months of death)

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Fractured hip

(b) Date of occurrence March 10-41

(c) Where did injury occur? Dr. Joseph Buchanan Mo
(City or town) (County) (State)

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

While at work? No (Specify type of place) (e) Means of injury Fall over

23. Signature R. J. Brennan (M. D. or other) _____
Address Chillicothe Mo Date signed 6/7/41

SUPPLEMENTARY

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

1941

S-11280