

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

19148
Do not use this space.

1. PLACE OF DEATH
 (a) County Saline Registration District No. 801
 (b) Township Liberty Primary Registration District No. 6045 Registered No. 47
 (c) City Houstonville Rural Street No. 1 St.
 (e) Length of residence in city or town where death occurred 5 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
 2. PRINT FULL NAME Elbert Evert Fluty
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Gertrude Shields
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 23
 7. AGE YEARS 60 MONTHS _____ DAYS _____ If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. farmer
 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) Ill.
 FATHER 13. NAME Stephen Fluty
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.
 MOTHER 15. MAIDEN NAME Quize Spencer
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) don't know
 17. INFORMANT (ADDRESS) R. E. Fluty Houstonville
 18. BURIAL, CREMATION, OR REMOVAL PLACE: Houstonville DATE May 31 1941
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Mathews Houstonville, Mo.
 20. FILED 5/30 1941 R. E. Fluty Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 28 1941
 22. I HEREBY CERTIFY, That I attended deceased from March 14 1941 to May 28 1941
 I last saw him alive on May 28 1941 Death is said to have occurred on the date stated above, at 8:30 P.M.
 The principal cause of death and related causes of importance were as follows:
Pulmonary Tuberculosis Date of onset ?
13/21
 Other contributory causes of importance:
Sancrene left lower about 4 days
Cardiac decompensation
 Name of operation _____ Date of _____
 What test confirmed diagnosis? X-Ray Was there an autopsy? no
 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? no
 If so, specify _____
 (Signed) Lesburn Ellis M. D.
 (Address) Sweet Springs, Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

17-97-9
District Health Officer No. 8
RECEIVED
District Health Officer No. 8
Federal File Number
Date Filed

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 H. H. Smiley

Licensed Embalmer No. 3987

P. O. Address Houston

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.

Registration District No. 801

Primary Registration District No. 6045

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Liberty
(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 _____

3. (a) PRINT FULL NAME Elbert Ewert Fultz

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color or race w

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Sept 23 1881
(Month) (Day) (Year)

8. AGE: Years 60 Months 8 Days 5 If less than one day _____ min.

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 _____ (State or foreign country)

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

16. (a) Informant _____ (b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pettis County

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

(d) Street No. _____ (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month May day 28
year _____ 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 _____

Due to _____

Due to _____

Other conditions _____ (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) _____ (Specify means of injury) _____

23. Signature Robert Ellis (M. D. or other)
Address Sweet Springs Date signed _____

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

MOTHER FATHER

SUPPLEMENTAL

S-19148 1941