

S. No. 2  
1-14-41  
5-17-39  
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DEPT. OF HEALTH  
OFFICE OF THE COMMISSIONER  
1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

24986  
State, File No.  
Registrar's No. 76

1 District No. 974 Primary Registration District No. 5387

1. PLACE OF DEATH:  
(a) County Douglas  
(b) City or town Rome Campbell Mo.  
(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. 1 (Specify whether  
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Douglas  
(c) City or town Rome  
(d) Street No. (If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME Dr. James Cameron Ellis  
3. (b) If veteran, name war  
3. (c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month June day 26  
year 1941 hour 6 minute 30 P.M.

4. Sex 0 Male  
5. Color or race White  
6. (a) Single, widowed, married, divorced, Widowed  
6. (b) Name of husband or wife Cora Metts Ellis  
6. (c) Age of husband or wife if alive years  
7. Birth date of deceased September 17, 1864  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 1940 to June 26 1941  
that I last saw him alive on June 26 1941 and that death occurred on the date and hour stated above.

8. AGE: Years 76 Months 9 Days 9  
If less than one day hr. min.

Immediate cause of death  
Duration  
Carcinoma right side of face and jaw.  
Due to 53

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

Other conditions (Include pregnancy within 3 months of death)  
Major findings:  
Of operations  
Of autopsy

10. Usual occupation Medical Doctor

11. Industry or business  
12. Name Issac Ellis  
13. Birthplace Coles County, Ill.  
14. Maiden name Eliza Jane Cameron  
15. Birthplace Coles County, Ill.

PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant Nora Ellis  
(b) Address Lewistown, Ill.

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?

17. (a) Burial (b) Date thereof 6-29-41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Walnut Grove

18. (a) Signature of funeral director Clinkingbeard Funeral Home  
(b) Address Ava, Missouri

(Specify type of place) (c) Means of injury  
23. Signature J. P. [Signature] (M. D. or other) D  
Address [Signature] M.D. Date signed 6-30-41

19. 7-17-1941 (b) [Signature] (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

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

34  
0  
0

RECEIVED

District Health Officer No. 6,

District File Number 841-1275-

Date Filed AUG 4 1949

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**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.....

*W.B. Hutchison*

Licensed Embalmer No. 3431

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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 24986  
Registrar's No. 76

Registration District No. 974

Primary Registration District No. 5387

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

**1. PLACE OF DEATH**

(a) County Douglas

(b) City or town Campbell Sup  
(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** Dr. James L. Ellis

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 wid

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

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

**8. AGE:** Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ (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 \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

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) 7-7-1941 (b) Reba K. White (Date received local registrar) (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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month \_\_\_\_\_ Day \_\_\_\_\_ Year 1941 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

**21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_

Duration \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

**SUPPLEMENTARY**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 24986  
Registrar's No. 76

Registration District No. 974 Primary Registration District No. 5381

1. PLACE OF DEATH:

(a) County Douglas  
(b) City or town Campbell Twp  
(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 Mo (b) County Douglas  
(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 Dr. James C. Ellis  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month June 1941 year 1941 day \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex m 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 \_\_\_\_\_ years  
7. Birth date of deceased: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

Immediate cause of death Carcinoma of jaw Duration \_\_\_\_\_  
right side face & jaw  
Due to not known

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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)

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)  
(b) 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 \_\_\_\_\_

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) 7-7 1941 (b) Reba B. White  
(Date received local registrar) \_\_\_\_\_ (Registrar's signature)

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTARY

PHYSICIAN  
Underline the cause to which death should be charged statistically.