

Primary Registration District No. _____

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County GASCONADE
(c) City or town ROSEBUD MO 037
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. 46 0 years.

3. (b) If veteran, name war.....	3. (c) Social Security No.....
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4. Sex female 5. Color or race white 6. (a) Single, ~~widowed~~, married ~~divorced~~ married

6. (b) Name of husband or wife Thomas 6. (c) Age of husband or wife 52 years

7. Birth date of deceased 5 16 1889
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	52	2	6	hr min

9. Birthplace Lithuania Europe X
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

12. Name George Worderle

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

OTHER { 14. Maiden name Sophia Anna Wondersle
15. Birthplace Lithuania 8

16. (a) Informant Thomas James Ellwood

(b) Address Hagerman Rd
B 1 2-31-41

17. (a) Burial (b) Date thereof 1-28-77
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place burial or cremation Roseland

18. (a) Signature of funeral director. E. J. Meyer

19. (a) 7-25-41 (b) Robert M. Munro

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 22
year 1941 hour 8:30 minute A M

21. I hereby certify that I attended the deceased from June 11, 1941, to July 22, 1944,
that I last saw her alive on July 21, 1944,
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<i>Chronic Encephalitis</i>	<i>Unknown</i>

Due to.....

[illegible]

Due to _____

Other conditions Heston 9 Central Kentucky 24
(Include occurrence within 3 months of birth)

Fracture of left fore arm

Major findings:
Of operations _____ Underlin

the cause to which death is attributed.

Of autopsy _____ should be charged statistically.

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

(b) Date of occurrence 7-5-68

(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 intercom _____

Y23. Signature Charles A. Schmal (or other) 79

*Address General Mo Date signed 9-78

(Licensed Embalmer's Statement on Reverse Side)

SEP 29 1947

10-2
S-8-M
IX

JOHN H. HARRIS

JOHN H. HARRIS

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 Robert M. Murray

Licensed Embalmer No. 3748

P. O. Address Owensville, 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

- (a) County Gasconade
(b) City or town Gasconade
(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 5
(Specify whether
In this community 5
years, months or days)

3. (a) PRINT
FULL NAME

Sophia A. Ellwood

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 SM

6. (b) Name of husband or wife W
6. (c) Age of husband or wife if
alive 5 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

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

16. (a) Informant

- (b) Address

17. (a) (b) Date thereof (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)

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 July Day 21
Year 1941 Hour 10 Minute 15 M.

21. I hereby certify that I attended the deceased from 1941 to 1941
that I last saw him alive on 1941 and that death occurred on the date and hour stated above.
Immediate cause of death Fracture of left forearm Duration

- Due to 186

- Due to 186

- Other conditions (Include pregnancy within 3 months of death)

- Major findings: Fracture of left forearm

- 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 June 11, 1941

- (c) Where did injury occur Gasconade, Mo.

- (d) Did injury occur in or about home, on farm, in On the road about home

- While at work? Working (Specify type of place) (e) Means of injury Fall

23. Signature Charles A. Schmitt (M. D. or other)

- Address Genee Date signed 9-16-41

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

SUPPLEMENTARY

S-25057