

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

28915
Do not use this space.

FILED SEP 13 1941

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 53
 (b) Township Anderson Primary Registration District No. 6262 Registered No. 89
 (c) City Paducah or (d) Street No. 1 St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Jeraline Ellison

(g) Residence, No. 0 St. 0 (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Albert Ellison
 Date of marriage March 28 - 1922
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) APRIL 28 - 1923
 7. AGE YEARS 18 MONTHS 5 DAYS 3 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House wife
 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) Paducah, Mo.

FATHER 13. NAME Jordan Jones

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wrensburg, Mo.

MOTHER 15. MAIDEN NAME Dollie Jones

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Johnstown, Mo.

17. INFORMANT (ADDRESS) Charley Ellison, Paducah, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Stanfield DATE Sept 2, 1941

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Robert B. Macomber, Paducah, Mo.

20. FILED Sept 2, 1941 J. Gordon Maccom Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) September 1, 1941

22. I HEREBY CERTIFY That I attended deceased from Aug 15, 1941, to Sept 1, 1941
 I last saw her alive on Aug 15, 1941 Death is said to have occurred on the date stated above, at 10:45 a.m.

The principal cause of death and related causes of importance were as follows:

Pulmonary Tuberculosis Date of onset —

Other contributory causes of importance: Dropsey

Name of operation none Date of —

What test confirmed diagnosis? clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? no Date of injury none, 19—

Where did injury occur? none (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury none

Nature of injury none

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) B. G. Grew M. D.

(Address) Paducah, Mo.

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.

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OCT 13 1949

RECEIVED

15.02
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District Health Office No. 2;

District File Number 941-1264

Date Filed 9/11/41

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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28915
Registrar's No. 89

Registration District No. 55

Primary Registration District No. 6262

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Gideon
(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 Missouri (b) County New Madrid
(c) City or town Gideon - - Rural
(If outside city or town limits, write "RURAL")
(d) Street No. EAST of Gideon
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Jeraline Ellison

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

4. Sex F 5. Color or race B 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 Mar 28, 1923
(Month) (Day) (Year)

8. AGE: Years 18 Months 5 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) Oct 11 - 41 (b) Jerald Ellison
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day _____ Year 1941 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her 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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (c) Means of injury _____

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

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

SUPPLEMENTARY

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