

Registration District No. **605**Primary Registration District No. **4359**

Registrar's No.

## 1. PLACE OF DEATH:

(a) County NEW MADRID  
 (b) City or town Camden  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
NON  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 In this community 12 Years (Specify whether  
 years, months or days)

2. (a) PRINT FULL NAME STELLA ELLISON3. (b) If veteran, name war NO 3. (c) Social Security No. NO4. Sex F 3 5. Color or race Col 6. (a) Single, widowed, married, divorced M 16. (b) Name of husband or wife W. M. Ellison (c) Age of husband or wife if alive \_\_\_\_\_ years7. Birth date of deceased Jan 24 1899  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
42 8 I hr. min.9. Birthplace ARK  
(City, town, or county) (State or foreign country)10. Usual occupation HOUSE WORK11. Industry or business NON12. Name Wesley Wiley  
13. Birthplace Ark  
(City, town, or county) (State or foreign country)14. Maiden name Mattie Tompson  
15. Birthplace Miss  
(City, town, or county) (State or foreign country)16. (a) Informant Ida Gaines  
(b) Address Sikeston, MO17. (a) CATRON MO (b) Date thereof 9/25 41  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation CATRON, M18. (a) Signature of funeral director Bill Brown(b) Address Sikeston, MO19. (a) 9-27-41 (b) D. H. H. H. H.  
(Date received local registrar) (Registrar's Signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County New Madrid **072**  
 (c) City or town Rural **0**  
 (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.? U.S. all time years **0**

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 23 Day  
year 1941 hour 2 P.M. minute \_\_\_\_\_ M.21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to 8-31- 1941,  
that I last saw him alive on 8-31- 1941,  
and that death occurred on the date and hour stated above.

Immediate cause of death

Unknown

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Of autopsy \_\_\_\_\_

Duration

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

## 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)  
(c) Means of injury X23. Signature G. N. Wilson (M. D. or other)  
Address Sikeston, MO Date signed 9-26-41

RECEIVED

District Health Office No. 2

District File Number 1041-1409

Date Filed 10/8/41

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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 G. Smith

Licensed Embalmer No. 2627

P. O. Address Gilbourn 410

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.

STANDARD CERTIFICATE OF DEATH

State File No. **32090**

Registration District No. **605**

Primary Registration District No. **4359**

Registrar's No. ....

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

**1. PLACE OF DEATH:**  
 (a) County New Madrid  
 (b) City or town Como 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)

**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** Stella Ellison  
 3. (b) If veteran, name war..... 3. (c) Social Security No.....

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month..... 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.....  
possible cardiac decomp

4. Sex F 5. Color of race B. 6. (a) Single, widowed, married, divorced.....  
 6. (b) Name of husband or wife W. M. Ellison 6. (c) Age of husband or wife if alive 48 years  
 7. Birth date of deceased Jan 24 1893  
(Month) (Day) (Year)

**8. AGE:** Years 42 Months 8 Days 14  
(If less than one day) min.

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

10. Usual occupation.....

11. Industry of 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) 11-12-41 [Signature]  
(Date received local registrar) (Registrar's signature)

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

Duration

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)

While at work?..... (e) Means of injury.....

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

Address..... Date signed.....

SUPPLEMENTARY

95c<sup>2</sup>

32090