

FILED DEC 10 1941
Registration District No. 675

Primary Registration District No. 6162

1. PLACE OF DEATH:

(a) County Vermon
(b) City or town Rural - Washington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hosp # 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 38 days
(Specify whether
In this community same years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Benton
(c) City or town Lincoln Mo
(If outside city or town limits, write "RURAL")
(d) Street No. None
(If rural, give location)
(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 8
year 1941 hour 6 minute 45 P. M.

21. I hereby certify that I attended the deceased from Oct 1
1941, to Nov 8, 1941
that I last saw her alive on Nov 8, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Apoptotic Pneumonia
Due to Heart failure

Due to Maniacal exhaustion

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

Major findings: _____
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 _____
(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 Dr. J. Creme (M. D. or other) _____

Address Madison Mo Date signed 11/8/41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

3. (a) PRINT FULL NAME Ella Ewert

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Female 6. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Albert Ewert 6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased December 20, 1897
(Month) (Day) (Year)

8. AGE: Years 43 Months 10 Days 18
If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Thelma Ewert

13. Birthplace Lincoln Mo
(City, town, or county) (State or foreign country)

14. Maiden name Thelma Wouch

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

16. (a) Informant Step. Reed

(b) Address Nevasa Mo

17. (a) Removal (b) Date thereof 11-8-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Mo

18. (a) Signature of funeral director W. C. Collett

(b) Address Lincoln Mo

19. (a) 11-8-41 (b) Allen V. Keys
(Date received local registrar) (Registrar's signature)

RECEIVED

District Health Officer No. 7,

District File Number 12-41-2006

Date Filed 12-9-41

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

J. B. Calbert

Licensed Embalmer No. 2500

P. O. Address Lincoln 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.

STANDARD CERTIFICATE OF DEATH

State File No. 39734

Registration District No. 875

Primary Registration District No. 6162

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Sturgeon
(b) City or town Sturgeon
(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 Ella Esper

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

4. Sex F 5. Color of race W. 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased Dec. 20 1893
(Month) (Day) (Year)

8. AGE: Years 43 Months 10 Days 1 (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) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____
to _____, 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 _____

Due to Pneumonia
bronchial

Due to _____

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

Major findings: _____
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 _____

(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 Wm J Greener (M. D. or Other) _____

Address St Paula Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

MOTHER FATHER

