

50140

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED OCT 9 1942

Registration District No. 74

Primary Registration District No. 5297

Registrar's No. 30-41

1. PLACE OF DEATH:

(a) County Clinton

(b) City or town Holt - Mo  
(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 Clinton

(c) City or town Holt -  
(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. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME George Edward Ellington

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

20. DATE OF DEATH: Month Sept day 28  
year 1942 hour 39 AM M.

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Oct 7 1872  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19 \_\_\_\_\_, to \_\_\_\_\_, 19 \_\_\_\_\_;  
that I last saw him alive on \_\_\_\_\_, 19 \_\_\_\_\_,  
and that death occurred on the date and hour stated above.

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

69 11 18 hr. min.

Immediate cause of death Coronary Occlusion Immediate Duration \_\_\_\_\_

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

10. Usual occupation Farmer

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

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

Other conditions (Include pregnancy within 3 months of death) 970

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Richard B. Ellington

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

14. Maiden name Marie Moore

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

Major findings: Of operations None

Of autopsy None

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically

16. (a) Informant's own signature Wilbert B. Ellington

(b) Address Kearney Mo

17. (a) Burial (b) Date thereof Sept 27 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Muddy fork

18. (a) Signature of funeral director Richard Gray

(b) Address Kearney

19. (a) Sept 27 - 42 (b) Tom A C Parker  
(Date received local registrar) (Registrar's signature)

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) (2) Means of injury 3

23. Signature of Richard Gray (Date of other) \_\_\_\_\_  
Address Reston Mo Date signed Sept 28 42

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

*Leonard Gray*

Licensed Embalmer No.....

*1677*

P. O. Address.....

*Kearney 4nd*

**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.**

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STANDARD CERTIFICATE OF DEATH

State File No. 30140  
Registrar's 30-41

Registration District No. 74

Primary Registration District No. 5297

1. PLACE OF DEATH:

Clinton

- (a) County.....
- (b) City or town.....  
(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 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

George Edward Ellington

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.....  
(MARRIED)

6. (b) Name of husband or wife.....

Naoma a

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

7. Birth date of deceased.....

Dec 7  
(Month) (Day) (Year)

8. AGE:

Years

69

Months

11

Days

If less than one day.....

min.

9. Birthplace.....

(City, town, or county)

(State or foreign country)

MO

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).....

(Burial, cremation, or removal)

(b) Date thereof.....

(Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a).....

(Date received local registrar)

(b).....

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month.....

year 1942

hour.....

minute.....

M.....

21. I hereby certify that I attended the deceased from.....

..... 19.....

that I first 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)

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

(Specify type of place)

While at work?.....

(c) Means of injury.....

23. Signature.....

(M. D. or other).....

Address.....

Date signed.....

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

MOTHER FATHER

SUPPLEMENTARY

