

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUL 13 1943 149

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 2956

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: General Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Day (Specify whether years, months or days)

In this community 13 Years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Edith Jane Ellis

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

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

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

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

7. Birth date of deceased Oct. 15th. 1877
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
65	8	16	hr. min.

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER {

12. Name James N. Paine

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

14. Maiden name Eleanor Haggan

15. Birthplace No Record
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. J.R. Ellis

(b) Address 4519 Chestnut

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 7-4-1943
(Month) (Day) (Year)

(c) Place: burial or cremation Dayton Cem. Garden City Mo.

18. (a) Signature of funeral director Mrs. C.L. Forster

(b) Address Kansas City, Missouri

19. (a) 7-3-43
(Date received local registrar)

(b) P. E. Brown
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 1001 Bales
(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 1st.
year 1943 hour 2 minute Am M.

21. I hereby certify that I attended the deceased from June 15th to June 30, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis

Arteriosclerosis

Due to Arterial Hypertension

Due to Acute Pancreatitis

Other conditions None
(Include pregnancy within 3 months of death)

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____

Of autopsy 440

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 A. M. Adkins (M. D. or other) Dr. 20

Address 473 Lee Bldg Date signed July 2-1943

Dr. Albert Adams
See Bldg 10th Floor
Ha 2224
1-4-

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 Denzil C. Browning

Licensed Embalmer No. 2724

P. O. Address K. P. no

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, fact should be so stated above.