

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.

FILED AUG 5 1943

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

24381  
Do not use this space.

1. PLACE OF DEATH 85-42

(a) County RUCHANAN Registration District No. 1001/1000

(b) Township \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registered No. 714

(c) City ST. JOSEPH (d) Street No. 0 ST. JOSEPH HOSPITAL St. 7  
(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 THOMAS LEROY ELI FRITS

(a) Residence, No. 420 Virginia St.  (If nonresident, give city or town and State) 0  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 9, 1943

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, . . . hrs. or <u>3.2</u> min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_

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) St. Joseph, Mo. Buchanan

13. NAME Elifrits, Lloyd G.

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Millersburg, Mo. Andrew County

15. MAIDEN NAME Elifrits, Amy

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ringgold County, Iowa

17. INFORMANT Lloyd G. Elifrits  
(ADDRESS) 4200 Virginia, St. Joseph, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Blythe Dale, Mo. DATE June 12, 1943

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Robert Herson  
6054 Chestnut Ave

20. FILED 6-10 1943 Rob Herson  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 9, 1943

22. I HEREBY CERTIFY, That I attended deceased from June 9, 1943 to June 9, 1943

I last saw him alive on June 9, 1943 Death is said to have occurred on the date stated above, at 10.10 a.m.

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

<u>Diffuse softening of brain</u>	Date of onset <u>6-8-43</u>
<u>atelectasis of lungs</u>	<u>6-9-43</u>

Other contributory causes of importance: 161a

Name of operation none Date of \_\_\_\_\_

What test confirmed diagnosis? autops Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

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

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

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

If so, specify \_\_\_\_\_

(Signed) Cabra Wortley, D. M. D.  
(Address) St. Joseph, Mo.

**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.....

*body was not embalmed*  
working under my personal supervision.

Registered Apprentice No.....

Signed..... *John E. Rupp*

Licensed Embalmer No. *3986*

P. O. Address..... *St. Joseph, 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.**