

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED AUG 12 1943  
98

Registration District No. 98

Primary Registration District No. 4164

1. PLACE OF DEATH:

(a) County Davess  
(b) City or town Alta Mont 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 3 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Davess  
(c) City or town Alta Mont  
(If outside city or town limits, write "RURAL")  
(d) Street No. 710 (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME

Elmer Ellsworth Kindig

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 31  
year 1943 hour 2 minute PM  
21. I hereby certify that I attended the deceased from 6-26-43  
to 7-31-43  
that I last saw him alive on 7/20-43  
and that death occurred on the date and hour stated above.

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex m 5. Color or race white  
6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Elzadas (c) Age of husband or wife if alive 70 years

7. Birth date of deceased June 6 1865  
(Month) (Day) (Year)

Immediate cause of death Carcinoma Prostate

8. AGE: Years 75 Months 1 Days 25 If less than one day hr. min.

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

10. Usual occupation Retired Hardware

Other conditions (Include pregnancy within 3 months of death) 51P

11. Industry or business

12. Name Samuel Kindig

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

14. Maiden name Mathew's Shipper

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

16. (a) Informant Elzadas Kindig

(b) Address Alta Mont Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-5-43  
(Month) (Day) (Year)

(c) Place: burial Alta Mont

18. (a) Signature of funeral director Mrs. Kate Shoup

(b) Address Whistler Mo

19. (a) 8-4-1943 (Date received local registrar) (b) A. O. Jackson (Registrar's signature)

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 0

23. Signature Fred W. Wilson (M. D. or other) 0  
Address Whistler Mo Date signed 8/2/43

Duration  
Operated  
2 yrs ago

PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

3100

**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.....

Licensed Embalmer No. *1180*

P. O. Address..... *Cameron, N.C.*

**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.**