

Registration District No. 157

Primary Registration District No. 3028

Registrar's No. 140

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

1. PLACE OF DEATH:

(a) County Jasper

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

(c) Name of hospital or institution:
400 S. Fulton St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 70 years (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Capitola Ellingsworth

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex female 5. Color or race white

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

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

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

7. Birth date of deceased January 29 1870
(Month) (Day) (Year)

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

<u>73</u>	<u>5</u>	<u>20</u>	hr. _____ min. _____
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9. Birthplace Dudleville Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business none

12. Name William Cahoon

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

14. Maiden name Margaret Wilson

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

16. (a) Informant Mrs. Sue Kyle

(b) Address 400 Fulton - Carthage, Mo.

17. (a) Burial (b) Date thereof July 21-'43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Carterville Cemetery

18. (a) Signature of funeral director Knell Mortuary

(b) Address Carthage Missouri

19. (a) July 21 '43 (b) Elyzabeth Couplin
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper

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

(d) Street No. 400 S. Fulton St.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19
year 1943 hour 11 minute 30 p.m.

21. I hereby certify that I attended the deceased from Jan. 29 1943 to July 19 1943
that I last saw her alive on July 19 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial heart failure

Due to _____

Due to _____

Other conditions 9222
(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) (c) Means of injury D

23. Signature R. A. Webster (M. D. or other) July 20
Address Carthage Mo. Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

48-1-633

OCT 7 1948

SEP 2 1948

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..... *Emm L. Kneel*
Licensed Embalmer No..... *391*
P. O. Address..... *Carthage*

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.