

EL SEP 10 1943
Registration District No. 93

Primary Registration District No. 4-1-5-4-5336 Registrar's No. 89

1. PLACE OF DEATH:

(a) County Dade
(b) City or town Greenfield, Rural, Center
(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 35 years (Specify whether)
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dade 29
(c) City or town Greenfield, Mo. Rural 0
(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? 0 years.

3. (a) PRINT FULL NAME Mary Ellen Elson

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

4. Sex F 5. Color or race white 6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife J.O. Elson 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov. 16, 1856
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
86 8 22 hr. min.

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

10. Usual occupation housewife

11. Industry or business _____

12. Name Lemuel Branson

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

14. Maiden name Elizabeth Branson

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

16. (a) Informant Mr & Mrs Will Elson

(b) Address Greenfield, Mo.

17. (a) Burial (b) Date thereof Aug 11 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Collins Cemetery

18. (a) Signature of funeral director E. Ray Caldwell

(b) Address Lockwood, Mo.

19. (a) Aug 10 '43 (b) Phyllis Lack
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 7th, 1943
year 1943 hour 10 minute 30 P.M.

21. I hereby certify that I attended the deceased from 4-12-1943 to 8-5-1943
that I last saw her alive on 8-5-1943 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Atherosclerosis Duration Disorder

Due to Arteriosclerosis
Nelrosia

Due to _____

Other conditions (Include pregnancy within 3 months of death) 938

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)

(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 P. D. Combs (M. D. or other) 0

Address Lockwood, Mo. Date signed 8-8-43

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

MOTHER FATHER

RECEIVED

District Health Officer No. 6,

District File Number 943-1013

Date Filed 9-9-43

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, ~~and~~

Registered Apprentice No. _____

working under my personal supervision.

Signed _____

License of Embalmer No. 3388

P. O. Address Lockwood

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.

State File No. _____

Registration District No. 93

Primary Registration District No. 5336

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Dade
(b) City or town Greenfield, Rural Center
(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

3. (a) PRINT FULL NAME

Mary Ellen Olson

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex ♀

5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Nov. 16
(Month) (Day) (Year)

8. AGE: Years 86 Months 8 Days 22
If less than one day _____ hr. _____ min.

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

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Phyllis Lack
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. year 1943 hour _____ minute _____ M.

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. 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)

(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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

28081