

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

29652

State File No.

Registrar's No.

Registration District No. 374

Primary Registration District No. 6272

## 1. PLACE OF DEATH:

- (a) County Worth  
(b) City or town Denver, Rural - Allen Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution (Specify whether

In this community 60 yrs  
years, months or days)3. (a) PRINT FULL NAME BESSIE ELLEN HOUSE

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Walter House 6. (c) Age of husband or wife if alive 69 years  
7. Birth date of deceased Jan 15 1876  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
67 5 6 hr. min.

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

10. Usual occupation
- Housewife

11. Industry or business

12. Name Cyrus McElvain  
13. Birthplace Illinois  
(City, town, or county) (State or foreign country)  
14. Maiden name Attie Beavers  
15. Birthplace Crawford Co Ohio  
(City, town, or county) (State or foreign country)

16. (a) Informant
- W. E. House

- (b) Address
- Allen Dale Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 23 1943  
(Month) (Day) (Year)

- (c) Place: burial or cremation
- New Hope Cemetery

- (d) Signature of funeral director
- Bram Bros

- (b) Address
- Denver Mo

19. (a) July 15 - 1943 (Date received local registrar) (b) Arline Seaden (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State MO (b) County Worth  
(c) City or town Rural Denver Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21  
year 1943 hour 7 minute 45 P.M.

21. I hereby certify that I attended the deceased from May 22  
1943 to June 21 1943  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of stomach Duration 6 mo

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 46 L

Of autopsy no

## 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 [Signature] M.D. or other \_\_\_\_\_  
Address Grand City Mo Date signed July 15 1943

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.....

working under my personal supervision.

*John Andrews Jr*

Registered Apprentice No.....

Signed.....

*John Andrews Jr*

Licensed Embalmer No.....

*4211*

P. O. Address.....

*Grant City, 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, fact should be so stated above.