

FILED OCT 9 1943 1944

Registration District No. ....

Primary Registration District No. 5710

Registrar's No. ....

1. PLACE OF DEATH?  
(a) County Mc Donald  
(b) City or town Jacket  
(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 38 yrs  
In this community 38 yrs  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County Mc Donald  
(c) City or town Jacket  
(If outside city or town limits, write "RURAL")  
(d) Street No. .... (If rural, give location)  
(e) Citizen of foreign country? (Yes or No) 0  
If yes, name country.....

3. (a) PRINT FULL NAME ALFRED FARRIS ELLIS

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Letta Ellis 6. (c) Age of husband or wife if alive 71 years  
7. Birth date of deceased May 3 1868  
(Month) (Day) (Year)

8. AGE: Years 75 Months 3 Days 28 If less than one day  
hr. .... min.

9. Birthplace Mc Donald Co Mo. (City, town, or county) (State or foreign country) 0

10. Usual occupation Farmer

11. Industry or business Farmer

MOTHER FATHER

12. Name Ben Ellis  
13. Birthplace Tenn (City, town, or county) (State or foreign country) 1  
14. Maiden name Leas Hall  
15. Birthplace Mo. (City, town, or county) (State or foreign country) 0

16. (a) Informant Clarence Ellis  
(b) Address Sea Ridge Ark

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4-43  
(Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director Ralph Miller  
(b) Address Sea Ridge Ark

19. (a) 10-8-43 (Date received local registrar) (b) Georgia Camp (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept day 1  
year 1943 hour 6 minute 45 P.M.

21. I hereby certify that I attended the deceased from Aug 1, 1943, to Aug 31, 1943  
that I last saw him alive on Aug 31 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to.....  
Due to.....

Other conditions (Include pregnancy within 3 months of death) 930

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 Wm. H. Salzer (M. D. or other) 0  
Address Cassville, Mo. Date signed.....

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

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

60  
0  
0

1240

**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.....

P. O. Address.....

**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.**