

ED NOV 12 1943  
Registration District No. **72**

Primary Registration District No. **5289**

1. PLACE OF DEATH:

(a) County **Clay**  
(b) City or town **North Kansas City Mo**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Home Gallatin Sup**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community **25 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Clay**  
(c) City or town **North Kansas City Mo**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **R-8 - No Kansas City Mo**  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **ROBERT WESLEY ELLINGTON**

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

4. Sex **Male** 5. Color of hair **White** 6. (a) Single, widowed, married, divorced **W-2**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **Dec - 24 - 1877**  
(Month) (Day) (Year)

8. AGE: Years **65** Months **9** Days **127** If less than one day hr. \_\_\_\_\_ min.

9. Birthplace **Conway Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Blacksmith**

11. Industry or business **Business**

12. Name **Marion J. Ellington**

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

14. Maiden name **Elizabeth Kinsler**

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

16. (a) Informant **Mrs Minnie Ellington**

(b) Address **R-8 No Kansas City Mo**

17. (a) **Burial** (b) Date thereof **Oct 23 - 43**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Clemwood Ceme.**

18. (a) Signature of funeral director **Morton Funeral Home**

(b) Address **North Kansas City Mo**

19. (a) **Oct 22 - 1943** (b) **Paul J. Henry**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** - day **21** - ST  
year **1943** - hour **7:15** - minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from **1908**  
\_\_\_\_\_, 19\_\_\_\_, to **10-21**, 19**43**  
that I last saw him - alive on **10-21**, 19**43**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Uremia** ✓  
Duration \_\_\_\_\_

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

Other conditions **Paralysis agitans**  
(Include pregnancy within 3 months of death)

Major findings: **J.R**  
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) (a) Means of injury \_\_\_\_\_

23. Signature **J. P. Hall** (M. D. or other) \_\_\_\_\_  
Address **624 Lafayette** Date signed **10-22-43**

MOTHER FATHER

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

NOV

RECEIVED

Sanitary Health Officer No. 8,

dated 11-11-43

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, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed John S. Morton

Licensed Embalmer No. 4349

P. O. Address Mo. Kansas City

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. *1111*

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County *Clay*  
(b) City or town *Rural*  
(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 *25yr.* years, months or days) (Specify whether

3. (a) PRINT FULL NAME *Robert W. Ellington*

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 *w*

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased *Dec. 24 1887*  
(Month) (Day) (Year)

8. AGE: Years *65* Months *9* Days \_\_\_\_\_ (Unless than one day) 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) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (Date received local registrar) (b) \_\_\_\_\_ (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 *Oct*, day \_\_\_\_\_, year *1943* hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death *Chronic Nephritis*  
Due to *Paralysis agitans*

Other conditions \_\_\_\_\_ (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) (e) Means of injury \_\_\_\_\_

23. Signature *J. R. Hoell* (M. D. or other) \_\_\_\_\_

Address *6276 K. K. Highway, D.C.* Date signed *11.15.43*

SUPPLEMENTARY

MOTHER FATHER

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

