

No. 2
-4-13
7-39
X37823

13965

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAY 11 1944

Registration District No. 2

Primary Registration District No. 400-95017

Registrar's No. 42

1. PLACE OF DEATH:

(a) County Andrew Savannah

(b) City or town NO DAWAY TOWNSHIP
(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 79 yrs. (Specify whether years, months or days)

In this community 79 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew

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

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? 0 (Yes No)
If yes, name country 0

3. (a) PRINT FULL NAME Lucy Ellen Elfrits

3. (b) If veteran, name war: -

3. (c) Social Security No. -

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 22
year 1944 hour 6 minute 40 P.M.

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife J. W. Elfrits

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

7. Birth date of deceased June 27 1864
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Apr 3rd 1944 to Apr 22nd 1944
that I last saw her alive on April 19 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Sclerosis Duration 7 yrs.

8. AGE: Years 79 Months 9 Days 27
If less than one day hr. min.

Due to.....

Due to.....

Other conditions (include pregnancy within 3 months of death) gfa

Major findings: Of operations.....

Of autopsy.....

9. Birthplace Andrew Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business.....

12. Name THOMAS MESSIK

13. Birthplace PLATE CO IOWA
(City, town, or county) (State or foreign country)

14. Maiden name ELIZABETH RAPICZ

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Mr. J. W. Elfrits

(b) Address Hillmore Mo

17. (a) B (b) Date thereof 4-24-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hillmore

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?.....

18. (a) Signature of funeral director E. C. Burt

(b) Address Savannah Mo

19. (a) 4-24-44 (b) J. H. Fitchman
(Date received local registrar) (Registrar's signature)

While at work? (Specify type of place) (c) Means of injury.....

23. Signature J. C. Hooker (M. D. or other)
Address Savannah Mo Date signed 4/24/44

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

MOTHER FATHER

1012

(Licensed Embalmer's Statement on Reverse Side)

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..... *E. L. Breit*

Licensed Embalmer No. *2650*

P. O. Address *Savannah, Ga.*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. may

Registration District No. 2 Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Andrew

(b) City or town _____
(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 Lucy Ellen Effects

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 m

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

7. Birth date of deceased June 27 1916
(Month) (Day) (Year)

8. AGE: Years 79 Months 9 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (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 April day 2 year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

13965