

FILED JUL 12 1944  
Registration District No. **289**

Primary Registration District No. **5737**

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

1. PLACE OF DEATH:  
(a) County **Malcoy Co**  
(b) City or town **Blue City, Indiana**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Johnson Hosp**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1** (Specify whether)  
In this community **35 years** (years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo** (b) County **Madison 61**  
(c) City or town **Rural** (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 \_\_\_\_\_

3. (a) PRINT FULL NAME **Mama Ellen Selby**  
3. (b) If veteran, name war **✓**  
3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **June** day **10**  
year **1944** hour **3** minute \_\_\_\_\_ P. M.

4. Sex **F** 5. Color of hair **W** 6. (a) Single, widowed, married, divorced **married**  
6. (b) Name of husband or wife **Dellat Selby** 6. (c) Age of husband or wife if alive **72**  
7. Birth date of deceased **May 22 1868**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **May 20** 19 **44** to **June 10** 19 **44**  
that I last saw her alive on **June 5** 19 **44**  
and that death occurred on the date and hour stated above.  
Immediate cause of death **circulatory collapse** Duration **3 days**

8. AGE: Years Months Days If less than one day  
**76** X **18** hr. min.

Due to **myocardial disease** **2 years**  
Due to **arteriosclerosis** **15 years**

9. Birthplace **Illinois U.S.A.** (City, town, or county) (State or foreign country)

Other conditions **none**  
(Include pregnancy within 3 months of death)

10. Usual occupation **House Keeper**

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name **Press Turner**  
13. Birthplace **not known**  
14. Maiden name **not known**  
15. Birthplace **not known**

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? \_\_\_\_\_

16. (a) Informant **John F. Young**  
(b) Address **Clarence, Mo.**  
17. (a) **Rural** (b) Date there **June 12 1944**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Nashville**

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature **Ralph W. Geller** (M. D. or other) **MD**  
Address **LaPlato Mo** Date signed **4/13/44**

18. (a) Signature of funeral director **J. Schriber**  
(b) Address **LaPlato Mo**  
19. (a) **6-13-44** (b) **Thom Leach**  
(Date received local registrar) (Registrar's signature)

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

