

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Free men
27055
State File No. _____
Registrar's No. 222

FILED SEP 10 1944
Registration District No. _____

Primary Registration District No. _____

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

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1602 S. Osteopathy
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
In this community Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair
(c) City or town Kirksville
(If outside city or town limits, write "RURAL")
(d) Street No. 1602 S. Osteopathy
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John G. Ellis

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, Divorced Widowed

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

7. Birth date of deceased Oct. 13 1864
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 8 10 hr. min.

9. Birthplace Wapello Co., Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name Daniel Ellis.

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

14. Maiden name Ellen Thompson

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

16. (a) Informant Ada Flynn

(b) Address Kansas City, Missouri

17. (a) Burial (b) Date thereof 8/25/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ownbev. Cemetery

18. (a) Signature of funeral director D. E. Riley
(b) Address Kirksville, Mo.

19. (a) 8-30-44 (b) Mr. J. L. Wagner
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 23
year 1944 hour 4:30 minute _____ P: M.

21. I hereby certify that I attended the deceased from Aug 21
1944 to Aug 23 1944
that I last saw him alive on Aug 22 1944
and that death occurred on the date and hour stated above.

Immediate cause of death:
Acute cardiac dilatation
+ myocardial failure
chronic myocarditis.
Due to Cholelithiasis - 3 days
(Gallstone calcic)

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

Major findings:
Of operations _____
Of autopsy _____
126

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) (Means of injury) _____
23. Signature Spencer L. Freeman MD.
Kirkville, Mo. (M.D. or other) _____
Address _____ Date signed 8/28/44

RECEIVED

District Health Officer No. 10

District File Number 9-44-1526

Date Filed SEP 7 1944

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 J. E. Riley

Licensed Embalmer No. 4181

P. O. Address Hicksville 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.