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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40506

FILED DEC 18 1944

State File No.

Registration District No.

Primary Registration District No. 3000

Registrar's No. 300

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 307 E. Jefferson  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1  
In this community all her life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Adair

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

(d) Street No. 307 E. Jefferson  
(If rural, give location)

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

3. (a) PRINT FULL NAME ELLAN N. WHITE

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 11 year 1944 hour 11 minute 30 A.M.

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced W.

6. (b) Name of husband or wife Noble J. 6. (c) Age of husband or wife if alive, years 25 1859

7. Birth date of deceased: (Month) 5 (Day) 25 (Year) 1859

21. I hereby certify that I attended the deceased from 1932 to Nov. 11 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 3 days

8. AGE: Years 85 Months 5 Days 16 If less than one day hr. 1 min.

Due to Arteriosclerosis

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

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

Other conditions (Include pregnancy within 3 months of death) Myocarditis, chronic

10. Usual occupation Housewife

Major findings: Of operations \_\_\_\_\_

11. Industry or business \_\_\_\_\_

Of autopsy 93th

12. Name Unknown

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

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 Chelie White

(b) Address Kirksville Mo

17. (a) Burial (b) Date thereof 11-12-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Park

18. (a) Signature of funeral director Gummerat Bull

(b) Address Kirksville Mo

19. (a) 11-14-44 (b) Mrs. J. L. Wayne  
(Date received local registrar) (Registrar's signature)

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 M.D.

Address Kirksville, Mo. Date signed 11/13/44

1049

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 10

District File Number 12-44-2063

Date Filed DEC 15 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

*W. C. Summers*

Licensed Embalmer No.

*2159*

P. O. Address

*Richsville*

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.