

S. No. 2
M-5-43
7. 5-17-39
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10834
Registrar's No. 34

FILED JAN 6 1945

Registration District No. 57

Primary Registration District No. 5211

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Dawn, Washington
(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 87ms (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll 17

(c) City or town Dawn (rural) 0
(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 Robert Eugene Ellis

3. (b) If veteran, name war _____ 3. (c) Social Security No. L

4. Sex M 5. Color or race wh 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased May 27 1944
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 23 year 1944 hour 11 minute 45 P.M.

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

8. AGE: Years Months Days If less than one day

X 6 29 hr. min.

Immediate cause of death Lobar Pneumonia Duration 3 days

Due to _____

Due to 108

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

10. Usual occupation Infant

11. Industry or business _____

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

Major findings: Of operations _____

Of autopsy _____

MOTHER FATHER

12. Name W. B. Ellis

13. Birthplace Carroll Co Mo
(City, town, or county) (State or foreign country)

14. Maiden name Mrs. R. E. Beuker

15. Birthplace Bay Co Mo
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant W. B. Ellis

(b) Address Dawn, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/44
(Month) (Day) (Year)

(c) Place: burial or cremation Norborne Cem

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 Raymond T. Mead

(b) Address Raymond Mo

19. (a) 12/24/44 (Date received local registrar) (b) Mrs. Edgar Smith (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury 3

23. Signature W. F. Smith (M.D. or Ch.D.)
Address W. F. Smith, Carrollton, Mo Date signed 12/24/44

1068

(Licensed Embalmer's Statement on Reverse Side)

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

Devinth L. Smith, Carrollton, Mo

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 *Bernard F. Mead*

Licensed Embalmer No. *2801*

P. O. Address *Braymer, 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.