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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 19 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 2

Registration District No. 104

Primary Registration District No. 4176

35
3
1

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

1. PLACE OF DEATH:

(a) County DUNKLIN

(b) City or town MALDEN
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
107-REAR N. MADISON
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution NONE
(Specify whether _____)

In this community 4 DAYS
years, months or days)

3. (a) PRINT FULL NAME PEARL ELLISON

3. (b) If veteran, name war NO.

3. (c) Social Security No. NO.

4. Sex 3 FEMALE 5. Color or race COLORED

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

6. (b) Name of husband or wife CHARLIE ELLISON

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased DECEMBER 12 1889
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>56</u>	<u>0</u>	<u>25</u>	hr. _____ min.

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

10. Usual occupation HOUSE WIFE

11. Industry or business ABOVE

MOTHER FATHER { 12. Name MATT TOIBERT

{ 13. Birthplace UNKNOWN ALABAMA
(City, town, or county) (State or foreign country)

{ 14. Maiden name Silvester Hattie

{ 15. Birthplace UNKNOWN UKA
(City, town, or county) (State or foreign country)

16. (a) Informant CHARLIE ELLISON

(b) Address CLARKTON, MO

17. (a) BURIAL (b) Date thereof 1-14-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Standfield Cemetery

18. (a) Signature of funeral director DAY FUNERAL HOME

(b) Address MALDEN MO.

19. (a) 1-12-45 (b) M. Deelder
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County DUNKLIN³⁵

(c) City or town CLARKTON, MO.⁰
(If outside city or town limits, write "RURAL") ⁰

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

(e) Citizen of foreign country? NO. (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JANUARY day 11
year 1945 hour 9 minute 50 P. M.

21. I hereby certify that I attended the deceased from Jan 9
1945 to Jan 11 1945
that I last saw her alive on Jan 11 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis -

Due to Disease of Heart

Due to W. atherosclerosis - Heart

Due to 3 sizes of normal

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

Major findings: ✓ 97d

Of operations ✓

Of autopsy ✓

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?
(Specify type of place) _____
While at work? ✓ (Specify means of injury) ✓

23. Signature L. S. Coates (M. D. or other) ✓
Address Malden Date signed Jan 11 1945

1288

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Office No. 2,

District File Number 245-150

Date Filed 2-7-45

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. D. Schuman
Licensed Embalmer No. 4086
P. O. Address Malden

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.