

FILED JAN 19 1945

Registration District No. **146**

Primary Registration District No. **3026**

Registrar's No. **340**

1. PLACE OF DEATH:

(a) County **Jackson**
 (b) City or town **Independence**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Independence Sanitarium & Hospital**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **0**
(Specify whether)
 In this community **0**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
 (c) City or town **Rural - Blue**
(If outside city or town limits, write "RURAL")
 (d) Street No. **2720 Sassafras Rd.**
(If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country **1**

3. (a) PRINT FULL NAME **Elbert Farly Willis**

3. (b) If veteran; name war.....
 3. (c) Social Security No. **500-12-1099**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **A**

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive **1** years

7. Birth date of deceased **September 26, 1884**
(Month) (Day) (Year)

8. AGE: Years **60** Months **3** Days **5** If less than one day hr. min.

9. Birthplace **Kenton, Tennessee**
(City, town, or county) (State or foreign country)

10. Usual occupation **Machine oper.**

11. Industry or business **Pratt & Whitney**

12. Name **Elbert E. Willis**

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

14. Maiden name **Melissa Jane Lee**

15. Birthplace **N.Y.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. L. L. Clow**

(b) Address **Independence, Mo.**

17. (a) **Burial** (b) Date thereof **1-2-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Main Grove Cem.**

18. (a) Signature of funeral director **Richard R. Speake**

(b) Address **Independence, Mo.**

19. (a) **1-2-1945** (b) **Jameau Reed**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **31**
 year **1944** hour **1** minute **35** A.M.

21. I hereby certify that I attended the deceased from **Dec 16**, 19**44**, to **Dec 31**, 19**44**;
 that I last saw him alive on **Dec 30**, 19**44**;
 and that death occurred on the date and hour stated above.

Immediate cause of death **Peritonitis - general** Duration 2 weeks

Due to **Perforated peptic ulcer** 2 wks.

Due to.....

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

Major findings: **Surgical repair**

Of operations.....

Of autopsy.....

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) (e) - Means of injury

23. Signature **Chas. Nelson Jr**
 Address **Indep. Mo** Date signed **1-2-45**

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

MOTHER FATHER

WHITE PLAINLY - USE UNFADING BLACK INK - MAKE A PERMANENT RECORD

1165

JAN 26 1945

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.....

Roland B. Speaks

Licensed Embalmer No. *3604*

P. O. Address *Grady, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 726
Registrar's No. 340

Registration District No. 146 Primary Registration District No. 3026

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Independence
(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 _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Elbert Early Willis
3. (b) If veteran, name war _____ 3. (c) Social Security No. 9

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Sept 26 1908
(Month) (Day) (Year)
8. AGE: Years 60 Months 3 Days _____ (Unless than one day) min.

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

10. Usual occupation _____

11. Industry or business _____
MOTHER FATHER { 12. Name _____
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 _____
(b) Address _____
17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____
19. (a) _____ (b) Comstock
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov at _____
year 1968 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____;
that I last saw him/her alive on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____ (include pregnancy within 3 months of death)
Major findings:
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?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

