

No. 2
1-5-43
5-17-39
I X38672

Registration District No. 160

Primary Registration District No. 3030

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

1. PLACE OF DEATH:

(a) County Jefferson
(b) City or town Festus
(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 1 (Specify whether)
In this community 1 years, months or days

3. (a) PRINT FULL NAME Amos I. Elliott

3. (b) If veteran, name war _____ 3. (c) Social Security No. 40-14-7556

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

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

7. Birth date of deceased June 16 1880
(Month) (Day) (Year)

8. AGE: Years 64 Months 6 Days 3 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Iron A. Elliott

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

14. Maiden name Sarah Koch

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

16. (a) Informant Becca May Elliott

(b) Address Festus Mo.

17. (a) Burial (b) Date thereof 12-23-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Festus Methodist Cem.

18. (a) Signature of funeral director Link Funeral Parlor

(b) Address Festus Mo.

19. (a) Dec 24 1944 (b) Virginia Williams, Jr.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson
(c) City or town Festus
(If outside city or town limits, write "RURAL")
(d) Street No. 402 Russell
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 19 year 1944 hour 11:00 minute 0 M.

21. I hereby certify that I attended the deceased from Dec. 19 1944, to _____ 1944, that I last saw him alive on Dec. 19 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

Due to _____
Due to _____

Other conditions Bronchial asthma
(Include pregnancy within 3 months of death)

Major findings:
Of operations 93d
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)
Means of injury _____

23. Signature Beccala Bolgar (M. D. or other)
Address Festus Mo. Date signed 12-23-44

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

135"

JAN 12 1958

RECEIVED

District Health Officer No. 9

District File Number

Date Filed

1-11-45

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

Eleana Province

Licensed Embalmer No.

3403

P. O. Address

Lester M

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2677

Registration District No. 160

Primary Registration District No. 3030

Registrar's No. 166

1. PLACE OF DEATH:
 (a) County Jefferson
 (b) City or town Leatun
(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

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 _____

3. (a) PRINT FULL NAME Ames J. Elliott
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July day 9
 year 1944 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 19____ to _____ 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 _____

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

7. Birth date of deceased June 6
(Month) (Day) (Year)
 8. AGE: Years 64 Months 6 Days no If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 Fink Funeral Parlor
 (b) Address _____

19. (a) _____ (b) Virginia Williams
(Date received local registrar) (Registrar's signature)

Due to _____
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____

Duration _____
 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

MOTHER FATHER

S-2677