

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3145
Registrar's No. 3

FILED FEB 13 1945

Registration District No. 211

Primary Registration District No. 3056

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Moberly
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 713 W. Coates
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether years, months or days)
In this community 1

3. (a) PRINT FULL NAME ELLA ALEXANDER

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

4. Sex Female 5. Color or race col 6. (a) Single, widowed, married, 3 divorced
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive 3 years
7. Birth date of deceased Jan 3 1944
(Month) (Day) (Year)

8. AGE: Years 51 Months 0 Days 0 If less than one day hr. min.

9. Birthplace MO
(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 Mrs. Francis Herber

(b) Address St. Joseph, MO

17. (a) Burial (b) Date thereof 1-7-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Moberly, MO

18. (a) Signature of funeral director P. L. Can

(b) Address Moberly, MO

19. (a) 1-7-45 (b) Prima Hall
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Randolph
(c) City or town Moberly
(If outside city or town limits, write "RURAL")
(d) Street No. 913 W. Coates
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 3
year 1945 hour 6 minute 45 P.M.

21. I hereby certify that I attended the deceased from Jan 3 1945 to Jan 3 1945
that I last saw her alive on Jan 3 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Breast & Liver & Stomach

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 50

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) (c) Means of injury

23. Signature M. L. McCormick (M. D. or other) MD

Address Moberly, MO Date signed 1-5-40

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

RECEIVED

District Health Officer No. 10

District File Number 2-45-308

Date Filed FEB 11 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

Licensed Embalmer No.

P. O. Address

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7-1
Registrar's No. 5

Registration District No. 294

Primary Registration District No. 3056

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Maherly
(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

Ella Alexander

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race B

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Jan 3

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

51

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)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

(b)

Irma Nave
(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 Jan Day 3 Year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

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)

Date signed _____

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

SUPPLEMENTARY

3145