

FILED MAR 6 1945

Primary Registration District No. 4771

Registrar's No. 7

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
4  
1  
0

1. PLACE OF DEATH:

(a) County Holt

(b) City or town Mound City  
(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) 1

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days)

In this community \_\_\_\_\_

3. (a) PRINT FULL NAME Ray Russell Elder.

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

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years (Day) (Year)

7. Birth date of deceased March 4 1901  
(Month) (Day) (Year)

8. AGE: Year 43 Months 11 Days 2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Joe Elder

13. Birthplace Ill. 1  
(City, town, or county) (State or foreign country)

14. Maiden name Arlina Graves

15. Birthplace Ill. 1  
(City, town, or county) (State or foreign country)

16. (a) Informant William Elder.

(b) Address Mound City Mo

17. (a) Burial. (b) Date thereof July 9-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mound City, Mo.

18. (a) Signature of funeral director W. G. Hoffman

(b) Address Mound City Mo.

19. (a) 2-9-45 (b) Pauline Dawson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County Holt 44

(c) City or town Mound City  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 6  
year 1945 hour 11 minute \_\_\_\_\_ P.M.

21. I hereby certify that I attended the deceased from Feb 4 to Feb 6 1945  
that I last saw him alive on Feb 6 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Influenza Edap  
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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature W. G. Hoffman (M. D. or other) \_\_\_\_\_  
Address Mound City Date signed 2/6/45

---

---

**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.....

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.**