

FILED MAR 7 1945

Registration District No. _____

Primary Registration District No. 3022

Registrar's No. 20

1. PLACE OF DEATH:

(a) County JOHNSON
(b) City or town WARRENSBURG
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
WARRENSBURG CLINIC
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 DAYS
(Specify whether
In this community 79 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JOHNSON
(c) City or town MAGNOLIA
(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 xxx

3. (a) PRINT FULL NAME MONTRECE HINDMAN ELLIOTT

3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE

4. Sex FEMALE 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 _____
7. Birth date of deceased SEPT 16 1874
(Month) (Day) (Year)

8. AGE: Years 70 Months 5 Days 2 If less than one day _____ hr. _____ min.

9. Birthplace JOHNSON CO MO
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEKEEPER

11. Industry or business AT HOME

MOTHER FATHER { 12. Name HUBERT ELLIOTT
13. Birthplace KENTUCKY
(City, town, or county) (State or foreign country)
14. Maiden name MONTRECE B HINDMAN
15. Birthplace KENTUCKY
(City, town, or county) (State or foreign country)

16. (a) Informant WILL ELLIOTT

(b) Address MAGNOLIA MISSOURI

17. (a) BURIAL (b) Date of death FEB 20 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation NEW LIBERTY

18. (a) Signature of funeral director Canada & Rapp

(b) Address Heldens Mo
19. (a) Feb 21 1945 (b) Leola M. Williams
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 18
year 1945 hour 8:15 minute A M.

21. I hereby certify that I attended the deceased from Feb-10-45
_____ 19____ to _____ 19____;
that I last saw her alive on 2-18-45 _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Chr. Myocarditis Duration ?

Due to _____
Due to 926
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? _____ (c) Means of injury _____

23. Signature R. F. McKim (M. D. or other) MD
Address Worshiping Mo Date signed 2-21-45

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

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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..... *M. J. Canaday*.....
Licensed Embalmer No.: *3434*.....
P. O. Address: *Holden, Mo.*.....

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.