No. 2
-8-43
-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37925

State File No.

FILED DEC 13 1945

Registration District No. 210 — Primary Registration District No. 6776 — Registrar's No. 72

1. PLACE OF DEATH:

(a) County Mercer
(b) City or town Rural - Washington Twp.
(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 3 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Mercer
(c) City or town Rural- Washington Twp.
(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

3. (a) PRINT FULL NAME Elzada Ash

3. (b) If veteran, name war

3. (c) Social Security No.

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec. (Month) 1 (Day) 1861 (Year)

8. AGE: Years	Months	Days	If less than one day
83	11	9	hr. min.

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

10. Usual occupation House Keeper

11. Industry or business

FATHER
12. Name Elaxander Hulvania
13. Birthplace Tenn. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Eliza Day
15. Birthplace Ill. (City, town, or county) (State or foreign country)

16. (a) Informant Fred Ash
(b) Address Trenton, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-23-45 (Month) (Day) (Year)
(c) Place: burial or cremation Princeton

18. (a) Signature of funeral director Martin Funeral Home
(b) Address Princeton, Mo.

19. (a) 11-23-45 (Date received local registrar) (b) Dwon Martin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 21st
year 1945 hour 7:30 minute A.M.

21. I hereby certify that I attended the deceased from October 18, 1945, to Nov 16, 1945; that I last saw her alive on November 13, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypostatic pneumonia	2 weeks
Due to: Fractured Hip	1 mo.
Due to: Generalized arteriosclerosis ?	
Other conditions (Include pregnancy within 3 months of death): Senile psychosis	2 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 Marian Lambert (M. D. or other)
Address Trenton Mo Date signed 11/21/45

1369 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 11,
District File Number _____
Date Filed _____

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 X. Ivan Martin

Licensed Embalmer No. 3760

P. O. Address Princeton, 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.

. No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 210 Primary Registration District No. 5776 Registrar's No. 72

1. PLACE OF DEATH:

(a) County Mercer
(b) City or town Rural Washington Twp
(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 years, months or days)
In this community

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 Elzada Ash

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec 1 1856
(Month) (Day) (Year)

8. AGE: Years 83 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov Day 21
year 1941 hour minute M.

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

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

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

22. If death was due to external causes, fill in the following: Fracture left
(a) Accident, suicide, or homicide (specify) Accident - femur
(b) Date of occurrence October 11, 1945 U.C.
(c) Where did injury occur? Grundy Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? At Home
(Specify type of place)
While at work? (e) Means of injury Fall outgh

23. Signature Marian Lambert (M.D. or other)
Address Date signed

SUPPLEMENTARY

37925