

S. No. 72
4-8-43
5-17-39
P1 X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42118

FILED JAN 12 1946

State File No.

Registration District No. 276

Primary Registration District No. 447-5947

Registrar's No. 14

1. PLACE OF DEATH:

(a) County Phelps
(b) City or town St. James, St. James, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Old Soldiers Home 5 Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 months
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Phelps 81
(c) City or town St. James 3
(If outside city or town limits, write "RURAL")
(d) Street No. _____ 0
(If rural, give location) _____ 0
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME FRANCIS ESTELLE ELLIS

3. (b) If veteran, name war _____ (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 Thomas G. Ellis 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 3 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
72 7 15 _____ hr. _____ min.

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

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER { 12. Name Esquire Cahill
13. Birthplace Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Mary Phelps
15. Birthplace not known 9
(City, town, or county) (State or foreign country)

16. (a) Informant Floyd Ellis 1
(b) Address St. James, Mo.

17. (a) Burial (b) Date thereof 12 20 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Bowen Cemetery

18. (a) Signature of funeral director Wesley W. White
(b) Address Owensville Mo.

19. (a) 12-24-45 (b) Cora E. Birmingham
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC. day 18
year 1945 hour 1 minute 30 P.M.

21. I hereby certify that I attended the deceased from October 4, 1945 to Dec 18, 1945
that I last saw him alive on Dec 18, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death fecal obstruction of bowels
Infect salt stroke 10 days
Duration 16 months

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations 1270
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) (e) Means of injury D

23. Signature William Brewer (M.D. or other) _____
Address St. James, Mo. Date signed 12-20-45

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

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

1487

(Licensed Embalmer's Statement on Reverse Side)

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 Me

....., Registered Apprentice No.....
working under my personal supervision.

Signed Wilford N N Winters
Licensed Embalmer No. 3838
P. O. Address Owensville 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. *Jan*Registration District No. *276*Primary Registration District No. *5947*Registrar's No. *14*

1. PLACE OF DEATH

- (a) County *Phelps*
 (b) City or town *Kurd St. James Twp*
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Soldiers Home Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution *13 months*
 (Specify whether

In this community _____
years, months or days3. (a) PRINT FULL NAME *Francis E. Ellis*3. (b) If veteran,
name war _____3. (c) Social Security
No. _____4. Sex *M* 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 _____7. Birth date of deceased *May 3*
(Month) (Day) (Year)8. AGE: Years *72* Months _____ Days _____ If less than one day
hr. _____ min. _____9. Birthplace _____
(City, town, or county) (State or foreign country) *Mo*

10. Usual occupation _____

11. Industry or business _____

MOTHER, FATHER { 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 _____

(b) Address _____

19. (a) *Jan 16, 1946* (b) *Cara E. Birmingham*
(Date received local registrar) (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 *Dec* year *1946* (hour) _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19 _____;

that I last saw him _____ alive on _____, 19 _____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

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 sta-
tistically.

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

42118