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2-43  
7-39  
235697

Registration District No. 150

Primary Registration District No. 5572

Registrar's No. 164

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Rural Prairie Twp  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Jackson County E. Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Mo. 27 days  
(Specify whether years, months or days)

In this community 1 year

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Independence  
(If outside city or town limits, write "RURAL")

(d) Street No. 9418 E. 16th  
(If rural, give location)

(e) Citizen of foreign country? ✓ (Yes or No)  
If yes, name country ✓

3. (a) PRINT FULL NAME FRANK M<sup>c</sup>Elwain

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race Wh.

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

6. (b) Name of husband or wife Carrie M<sup>c</sup>Elwain

6. (c) Age of husband or wife if alive 1 years

7. Birth date of deceased April 27<sup>th</sup> 1866  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>7</u>	<u>16</u>	hr. min.

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

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER

12. Name David M<sup>c</sup>Elwain

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

14. Maiden name Fancy Ellen Nickerson

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

16. (a) Informant Vertie May Kennigut

(b) Address 9418 E 16th St

17. (a) Burial (b) Date thereof 12-18-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Geo. C. Carson Fun. Home

(b) Address Independence, Mo

19. (a) 12/18/45 (b) Asa S. Dunbar  
(Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 16<sup>th</sup>  
year 1945 hour 9 minute 00 a.m.

21. I hereby certify that I attended the deceased from 10-19-45  
to 12-13-45

that I last saw him alive on 12-13-45

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

Immediate cause of death Nephritis

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external cause, 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 F. W. Tuttle (M. D. or other) MD  
Address Blue Springs Mo Date signed 12/45

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

10045A

**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.....

*George L. Hanson*

Licensed Embalmer No.....

*2249*

P. O. Address.....

*Independence 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 226  
Registrar's No. 164

Registration District No. 150 Primary Registration District No. 5572

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Rural Preminger  
(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 Frank McElwan  
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 \_\_\_\_\_ years  
7. Birth date of deceased Apr 24 (Month) (Day) (Year)

8. AGE: Years 80 Months 7 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ 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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (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 \_\_\_\_\_ Day \_\_\_\_\_ Year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Duration \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Due to \_\_\_\_\_

Due to \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
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 \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

100454

SUPPLEMENTARY

MISSOURI  
INFORMATION  
SUPPLEMENTARY  
ADDITIONAL

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

2957