

**FILED MAY 14 1946 STANDARD CERTIFICATE OF DEATH**

State File No. **12752**

Registration District No. **109**

Primary Registration District No. **5424**

Registrar's No. **9**

**1. PLACE OF DEATH:**

(a) County **Dunklin**  
 (b) City or town **Campbell R. 3 Union**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: **Home**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution: **76 years** (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Missouri** (b) County **Dunklin 35**  
 City or town **Campbell R. 3**  
 (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 **Wilbryn Tennessee McElyea**

3. (b) If veteran, name war: \_\_\_\_\_ 3. (c) Social Security No. **none**

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

6. (b) Name of husband or wife **Lee Ambrose Daniel McElyea** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased **September 24 1855**  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>90</b>	<b>7</b>	<b>6</b>	_____ hr. _____ min.

9. Birthplace **Union County, Tennessee**  
 (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

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

**MOTHER FATHER**

12. Name **Alfred Booth**  
 13. Birthplace **unknown**  
 (City, town, or county) (State or foreign country)  
 14. Maiden name **Lucy Brooks**  
 15. Birthplace **unknown**  
 (City, town, or county) (State or foreign country)

16. (a) Informant **A. E. McElyea**

(b) Address **Campbell, Mo R. 3**

17. (a) **Burial** (b) Date thereof **5-2-46**  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Gravel Hill Mo**

18. (a) Signature of funeral director **Sanders Funeral Home**

(b) Address **Campbell Mo**

19. (a) **5/1/46** (b) **Mr. Burial Campbell**  
 (Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **April** day **30**  
 year **1946** hour \_\_\_\_\_ minute **9:45 A.M.**

21. I hereby certify that I attended the deceased from **March 20<sup>th</sup> 1946** to **Apr. 27<sup>th</sup> 1946**  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Terminal Hypo-static Broncho-pneumonia** Duration **3 days**

Due to **Old Fr. neck Right Femur** 6 hrs.

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

Other conditions **Semility**  
 (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:

(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 **Wallace A. Selvey** (M. D. or other) **MD**  
 Address **Campbell Mo** Date signed **5/1/46**

RECEIVED

District Health Office No. 2

District File Number 546-617

Date Filed 5-18-46

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 Christina M. Sanders

Licensed Embalmer No. 4227

P. O. Address Campbell, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. May  
Registrar's No. 90

Registration District No. 109 Primary Registration District No. 542K

1. PLACE OF DEATH:  
(a) County Shunklin  
(b) City or town Rural  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Wilbur J. McElyea  
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 \_\_\_\_\_ days \_\_\_\_\_ hr. \_\_\_\_\_ min.

7. Birth date of deceased Sept 2 (Month) (Day) (Year)  
8. AGE: Years 90 Months \_\_\_\_\_ 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)  
(Burial, cremation, or removal) (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 \_\_\_\_\_ 1946 year \_\_\_\_\_ 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 \_\_\_\_\_

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 causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Accident  
(b) Date of occurrence Dec. 3, 1945  
(c) Where did injury occur? Union Twp. Shunklin Mo. (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home  
While at work? no (Specify type of place) (e) Means of injury Fall  
23. Signature Wallace Belsey (M. D. or other) MD  
Address Campbell Mo. Date signed 5/21/46

SUPPLEMENTARY

WHILE FLAINLY - USE UNFADING BLACK INK - MAKE A PERMANENT RECORD

11657

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