S. No. /
M—8-43
. 5-17-39
I 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

State File No. 23971

FILED JUL 16 1946

Registration District No. 15 7 — Primary Registration District No. 3028 — Registrar's No. 106

1. **PLACE OF DEATH:**
(a) County Jasper
(b) City or town Carthage
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: McCune-Brooks Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 month (Specify whether
In this community 50 years years, months or days)

2. **USUAL RESIDENCE OF DECEASED:**
(a) State Missouri (b) County Jasper
(c) City or town Carthage
(If outside city or town limits, write "RURAL")
(d) Street No. 744 W. Central Ave.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Elvira Dennison
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 married
6. (b) Name of husband or wife John W. Dennison
6. (c) Age of husband or wife if alive 61 years
7. Birth date of deceased August (Month) 3 (Day) 1887 (Year)

8. **AGE:** Years 59 | Months 10 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Sarcoxie (City, town, or county) Missouri (State or foreign country)
10. Usual occupation at home
11. Industry or business ----

MOTHER FATHER
12. Name Frank I. Taylor
13. Birthplace unknown (City, town, or county) Illinois (State or foreign country)
14. Maiden name Sarah A. ----
15. Birthplace unknown (City, town, or county) Missouri (State or foreign country)

16. (a) Informant John W. Dennison
(b) Address 744 W. Central, Carthage, Mo.
17. (a) burial (Burial, cremation, or removal) (b) Date thereof June 7, 1946 (Month) (Day) (Year)
(c) Place: burial or cremation Park Cemetery
18. (a) Signature of funeral director Knell Mortuary
(b) Address Carthage, Mo.
19. (a) 6-6-46 (Date received local registrar) (b) L. B. Clinton M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month June day 5
year 1946 hour 3:25 minute a M.
21. I hereby certify that I attended the deceased from April 11, 1946 to June 5, 1946
that I last saw her alive on June 4th, 1946;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Primary Carcinoma Pancreas & Liver	
Due to	
Due to Cachexia	
Other conditions Uraemia (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy Primary carcinoma Head of Pancreas - liver metastases	

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Lloyd B Clinton (M. D. or other) M.D.
Address Carthage Mo. Date signed 6/5/46

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(Licensed Embalmer's Statement on Reverse Side)

46-6-586

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

Frank W Kneel Jr, Registered Apprentice No. 379

working under my personal supervision.

Signed Emma L Kneel

Licensed Embalmer No. 391

P. O. Address Carthage

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.

S. No. 2B
M—3-45
I X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. aug

Registration District No. 157 Primary Registration District No. 2028 Registrar's No. 1067

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

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Carthage
(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 Elvira Dennison

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 M

6. (b) Name of husband or wife

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

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

8. AGE: Years 57 | Months 10 | 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)

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MEDICAL CERTIFICATION

20. DATE OF DEATH: Month aug Day 3 year 1945 hour 5 minute PM.

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.

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

SUPPLEMENTARY

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature L B Clinton M D (M. D. or other)

Address Date signed

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