

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39352**

FILED NOV 20 1946

Registration District No. _____

Primary Registration District No. **6149**

Registrar's No. **20**

1. PLACE OF DEATH:

(a) County **Stoddard**

(b) City or town **Payson 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 **15 days**
years, months or days

3. (a) PRINT FULL NAME **Rosa Adeline Elledge**

3. (b) If veteran, name war _____ No. _____

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 **Sam Elledge**

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

7. Birth date of deceased **See 13 1880**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
65	9	29	hr. _____ min. _____

9. Birthplace: **Bollinger Co. Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation: **Housewife**

11. Industry or business:

12. Name: **Monroe Fowler**

13. Birthplace: **Bollinger Co. Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name: **Mary Morris**

15. Birthplace: **Not known**
(City, town, or county) (State or foreign country)

16. (a) Informant: **Mrs. Laine Keville**

(b) Address: **Knappsville Mo.**

17. (a) Burial (b) Date thereof **Oct 15 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Clubbs Creek**

18. (a) Signature of funeral director: **Glad Morgan**

(b) Address: **Payson Mo.**

19. (a) 10/22/46 (b) **Glad Morgan**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Stoddard**

(c) City or town **Advance (Rural)**
(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 **Oct.** day **12**
year **1946** hour **8** minute **30** P.M.

21. I hereby certify that I attended the deceased from _____, 1940 to **Oct. 12**, 1946
that I last saw her alive on **Sept.**, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis**

Due to **Bronchial asthma and Scirrhus**

Due to _____

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

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: **E. C. Mestas** (M. D. or other) **Mo.**

Address **Advance Mo.** Date signed **10-22-46**

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Office No. 2,

District File Number 1146-1316

Date Filed 11-17-46

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.....

Licensed Embalmer No.....

P. O. Address.....

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.