

Registration District No. **61**

Primary Registration District No. **4107**

Registrar's No. **2**

1. PLACE OF DEATH:

(a) County **Cedar**
(b) City or town **El Dorado Springs**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Adult Convalescent Home 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 year**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Cedar**
(c) City or town **El Dorado Springs**
(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 **Ellen Smith**

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married. **2 divorced Widowed**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: **May 23 1865**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 7 14 hr. min.

9. Birthplace: **Cedar Co Mo. 7**
(City, town, or county) (State or foreign country)

10. Usual occupation: **Housewife**

11. Industry or business _____

MOTHER FATHER
12. Name **Phara Ward**
13. Birthplace **Unknown 9**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown 7**
(City, town, or county) (State or foreign country)

16. (a) Informant **Phara Ward Castle**
(b) Address **Carthage, Mo.**

17. (a) **Burial** (b) Date thereof: **1-8-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Hazel Dell**

18. (a) Signature of funeral director **Livina Crocker**
(b) Address **El Dorado Spgs. Mo.**

19. (a) **1/7/47** (b) **J. C. [Signature]**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **6**
year **1947** hour **7** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **Dec. 30 1946**, to **Jan. 4 1947**, that I last saw her alive on **Jan. 4 1947**, and that death occurred on the date and hour stated above.

Immediate cause of death: **Bronchial Pneumonia**

Due to _____
Due to _____

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

Major findings:
Of operations _____
Of autopsy **107**

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 **2**
23. Signature **C. H. [Signature]** (M. D. or other) **100**
Address **El Dorado Spgs. Mo.** Date signed **1-8-47**

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

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

CT-9-8
ET-CT-1

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 *Floyd E. Carsthus*
Licensed Embalmer No. *4419*
P. O. Add. *Gold Dunes Spring, Md.*

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.