

THE STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

4343

State File No. ....  
 Registrar's No. 12

Registration District No. 73 Primary Registration District No. 6291

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

1. PLACE OF DEATH:  
 (a) County CLAY  
 (b) City or town Liberty  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
I.O.O.F Home  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution INSTITUTION  
 (Specify whether years, months or days) 6 years

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo (b) County CLAY  
 (c) City or town RURAL RT #3  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. IOOF HOME  
 (If rural, give location)  
 (e) Citizen of foreign country? NO (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ELLA LAURA TIMMONS  
 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 SINGLE  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Nov 23 1864  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
82 2 8 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace MADISON OHIO  
 (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business Unknown

12. Name THOMAS F. TIMMONS

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

14. Maiden name MARY DIMMIS DAUGHERTY

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

16. (a) Informant J. E. THOMAS (Supt)

(b) Address IOOF HOME, LIBERTY, MO.

17. (a) Removal (b) Date thereof 12-31-47  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill Cemetery

18. (a) Signature of funeral director Culver - Underwood  
 (b) Address Butler Mo.

19. (a) Jan 31 1947 (b) Minnie Hayes  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 31  
 year 1947 hour 7 minute 25 AM/PM  
 21. I hereby certify that I attended the deceased from Jan 29, 1947, to Jan 29, 1947;  
 that I last saw her alive on Jan 29, 1947,  
 and that death occurred on the date and hour stated above.

Immediate cause of death General arteriosclerosis  
Senility  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Duration \_\_\_\_\_

PHYSICIAN  
 Major findings:  
 Of operations 97  
 Of autopsy \_\_\_\_\_  
 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 U  
 23. Signature Wm H Goodson (M.D. or other)  
 Address Liberty Date signed 1/31/47

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 2-15-47

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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 John G. Howard  
Licensed Embalmer No. 3585  
P. O. Address Butler 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.

Registration District No. 7.3 Primary Registration District No. 5291

1. PLACE OF DEATH:

(a) County Clay  
(b) City or town Rural Liberty  
(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 Elle L. Timmon

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 5

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Mar. 23 1947  
(Month) (Day) (Year)

8. AGE: Years 82 Months 2 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business Unknown

MOTHER FATHER

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 \_\_\_\_\_ (Burial, cremation, or removal) (Month) (Day) (Year)

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

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

(b) Address Butler Mo.

19. (a) \_\_\_\_\_ (b) Miss H. Jones  
(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 Jan Day 1 Year 1947 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

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

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

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

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

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S-4343