. S. No. 2
M—9-4-41
ev. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 31 1947

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

8006

State File No.

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 407

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 39 yrs 9 mos 28 days (Specify whether
In this community 39 yrs. 9 mos, 28 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Holt
(c) City or town Oregon Mo
(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 Ella O'Fallon
3. (b) If veteran, name war Nil
3. (c) Social Security No. Nil
4. Sex Female
5. Color or race White
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 1862 (Month) (Day) (Year)

8. AGE: Years 85 Months ? Days ? If less than one day hr. min.

9. Birthplace Nat quen (City, town, or county) (State or foreign country)
10. Usual occupation Nil
11. Industry or business at home
FATHER
12. Name A. J. O'Fallon
13. Birthplace Nat quen (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 A. J. O'Fallon
(b) Address Oregon Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 23 47 (Month) (Day) (Year)
(c) Place: burial or cremation Oregon Mo
18. (a) Signature of funeral director James H Pettijohn
(b) Address Oregon Mo
19. (a) 3-24-47 (Date received local registrar) (b) E. C. Jenkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 21 year 1947 hour 2 30 minute P M.
21. I hereby certify that I attended the deceased from Jan 1, 1947 to Mar 21, 1947 that I last saw her alive on Mar 21, 1947 and that death occurred on the date and hour stated above.
Immediate cause of death Myocarditis arteriosclerosis suddenly
Due to advanced age
Due to —
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations 93D
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) No
(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 E. C. Cossins M.D. (M. D. or other)
Address State Hospital #2 Date signed 3/21 1947

282 (Licensed Embalmer's Statement on Reverse Side) St. Joseph, Mo.

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 James N. Pettijohn

Licensed Embalmer No. 3192

P. O. Address Oregon, 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.