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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 10 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30026

Registration District No. 324

Primary Registration District No. 3072

Registrar's No. 167

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Marshall, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Fitzgibbon Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 16 hrs
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo. (b) County Saline 97
(c) City or town Miami "Rural"
(If outside city or town limits, write "RURAL")
(d) Street No. Rt. 1 6 mi N.E. Miami
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME MICHAEL WAYNE ELSON

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

4. Sex MO 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 aug - 10 - 1947
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 0 If less than one day 16 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Murrel Arthur Elson
13. Birthplace De Witt Mo
(City, town, or county) (State or foreign country)
14. Maiden name Rosemary Ellen Knudsen
15. Birthplace Corder Mo
(City, town, or county) (State or foreign country)

16. (a) Informant M. A. Elson
(b) Address Miami Mo

17. (a) Burial (b) Date thereof: 8-11-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sweet Spring Mo
18. (a) Signature of funeral director Harry Hershberger
(b) Address Marshall Mo

19. (a) AUG. 12 1947 Sidney J Gray
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month aug day 11
year 1947 hour 1 minute 00 A.M.

21. I hereby certify that I attended the deceased from Aug 10 1947 to Aug 11 1947
that I last saw him live on Aug 10 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Perinatal - 7 month
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: 159
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) (c) Means of injury _____
23. Signature [Signature]
Address [Address] Date signed [Date]

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER-FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED
District Health Officer No. 8,

District File Number _____
Date Filed 9-9-47

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.....

was not embalmed....., Registered Apprentice No.....
working under my personal supervision.

Signed..... Harry Hersberger
Licensed Embalmer No. 435-7
P. O. Address Marshall 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.