No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 11 '947

Registration District No. 49

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

31184

State File No.

Registrar's No. 4185

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days (Specify whether
In this community 7 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson 48
(c) City or town Blue Springs
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME Odessa Ellis
3. (b) If veteran, name war — no
3. (c) Social Security No. none
4. Sex F M 1
5. Color or race W
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife unknown
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Aug (Month) 20 (Day) 1884 (Year)

8. AGE: Years 63 Months 1 Days 12 If less than one day hr. min.

9. Birthplace Carrol Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation Retired
11. Industry or business
FATHER
12. Name James F Brock
13. Birthplace Carrol Co (City, town, or county) Mo (State or foreign country)
MOTHER
14. Maiden name Missouri Powell
15. Birthplace Carrol Co (City, town, or county) Mo (State or foreign country)
16. (a) Informant Mrs W. E. Calloway
(b) Address Blue Springs Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-47 (Month) (Day) (Year)
(c) Place: burial or cremation Blue Springs Mo
18. (a) Signature of funeral director Mrs G B Wilkinson
(b) Address Blue Springs Mo
19. (a) 10-4-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct 2 day
year 47 hour 1:10 minute P M.
21. I hereby certify that I attended the deceased from Dec 1945 to Oct 2 1947;
that I last saw h alive on 19
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardiac failure	
Due to operation abdominal-perineal resection	
Due to Adenocarcinoma of colon	6 mo.
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations Adenocarcinoma of sigmoid colon
Of autopsy 46 l

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury 0
23. Signature M. R. Bay (M. D. ~~or other~~)
Address Blue Springs Mo Date signed 10/3/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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.....R B Webb.....

Licensed Embalmer No.....2353.....

P. O. Address.....Blue springs 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.