

FILED OCT 7 1947

Registration District No. **184**

Primary Registration District No. **3038**

Registrar's No. **71**

1. PLACE OF DEATH:

(a) County **LINN**
(b) City or town **BROOKFIELD**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
625 N. MAIN ST
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **72 YRS** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **Linn 58**
(c) City or town **BROOKFIELD** (If outside city or town limits, write "RURAL")
(d) Street No. **625 N. MAIN** (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **IDA ELLENBERGER**

3. (b) If veteran, name war **NONE** 3. (c) Social Security No. **NONE**

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **S**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **SEPT. 5, 1874**
(Month) (Day) (Year)

8. AGE: Years **73** Months **0** Days **5** If less than one day _____ hr. _____ min.

9. Birthplace **OTTUMWA IOWA**
(City, town, or county) (State or foreign country)

10. Usual occupation **NURSE - RETIRED**

11. Industry or business _____

12. Name **MARTIN ELLENBERGER**

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

14. Maiden name **JULIA ANN POTTS**

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

16. (a) Informant **MRS. ORPHA RIECK**

(b) Address **BROOKFIELD, MO**

17. (a) **BURIAL** (b) Date thereof **9-16-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **ROSE HILL CEMETERY**

18. (a) Signature of funeral director **RUSK FUNERAL HOME**

(b) Address **BROOKFIELD, MO**

19. (a) **9/16/47** (b) **Walter Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **SEPT** day **14**
year **1947** hour **4** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **August 16, 1947** to **Sept 14, 1947**
that I last saw him alive on **Sept 13, 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of Pines** Duration **None**
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

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

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 **Walter Brown** (M. D. or other) **9/15/47**
Address **Brookfield Mo** Date signed

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

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OCT 21 1947

OCT 30 1957

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..... *Harold B. Wright*

Licensed Embalmer No. *3718*

P. O. Address..... *Brookfield, 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.