No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 1 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37118

Registration District No. 42 | Primary Registration District No. 1000 | Registrar's No. 1384

1. PLACE OF DEATH:

(a) County Buchanen
(b) City or town St Joseph (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Rose Leon Nursing Home 624 Prospect (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 months (Specify whether years, months or days) In this community 21 months

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County De Kalb
(c) City or town Amity (If outside city or town limits, write "RURAL")
(d) Street or R.F.D. No. Amity (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3. (a) PRINT FULL NAME Della Ellis

3. (b) If veteran, name war no
3. (c) Social Security No. none
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Greene Ellis
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July 10 1869 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
78	4	8	hr. min.

9. Birthplace ----- (City, town, or county) Indiana (State or foreign country)
10. Usual occupation House wife
11. Industry or business

MOTHER FATHER
12. Name Jim Thrasher
13. Birthplace Unknown (City, town, or county) unknown (State or foreign country)
14. Maiden name Della Palmer
15. Birthplace Unknown (City, town, or county) unknown (State or foreign country)

16. (a) Informant C. E. Healey
(b) Address Cincinnati Ohio
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-19-1947 (Month) (Day) (Year)
(c) Place: burial or cremation Amity Mo.
18. (a) Signature of funeral director John B. Brown
(b) Address Maryville Mo
19. (a) 11-24-47 (Date received local registrar) (b) Ora E. Jenkins (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Nov. day 18 year 1947 hour 6:10 minute A. M.
21. I hereby certify that I attended the deceased from Oct. 7 1947 to Nov. 18 1947 that I last saw her alive on 11/17 1947 and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Myocardial failure 1 hr.
Due to Chronic myocarditis 5 yr.
Due to Carcinoma? stomach 1 yr.
Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy None

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? (Specify type of place)
While at work? (e) Means of injury? 0

23. Signature W. [illegible] (M.D. or other)
Address St Joseph Date signed 11/20/47

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

(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.....

Licensed Embalmer No. 3933

P. O. Address. Maysville

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..