

Registration District No. **42**

Primary Registration District No. **1000**

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:  
**Rose Leon Nursing Home 624 Prospect Ave. Amity**  
(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 **2 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) 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 2**

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 **78** Months **4** Days **8**  
If less than one day hr. min.

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

10. Usual occupation **House wife**

11. Industry or business

12. Name **Jim Thrasher**

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

14. Maiden name **Della Palmer**

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

16. (a) Informant **G. E. Healey**

(b) Address **Cincinnati Ohio**

17. (a) **Burial** (b) Date thereof **11-19-1947**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Amity Mo.**

18. (a) Signature of funeral director **John P. Brown**

(b) Address **W. O. ...**

19. (a) **11-24-47** (b) **W. O. Jenkins**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **18**  
year **1947** hour **6:10** minute **AM**

21. I hereby certify that I attended the deceased from **Oct 7**  
**1947** to **Nov 18, 1947**  
that I last saw **et** alive on **11/17/47**  
and that death occurred on the date and hour stated above.

Immediate cause of death **myocardial infarction**  
Due to **chronic myocarditis & carcinoma of stomach**

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy **none**

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? (7) Means of injury

23. Signature **W. O. Jenkins** (M. D. or other)  
Address **St. Joseph, Mo.** Date signed **11/20/47**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

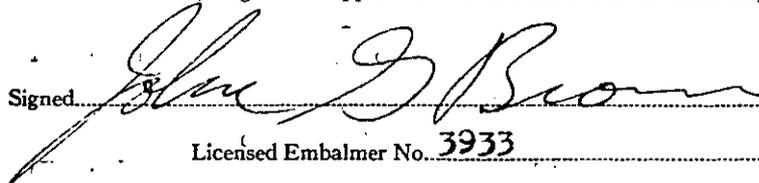
MOTHER FATHER

1-24-47

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.....

....., 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..**