

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **36243**
Registrar's No. **149**

FILED NOV 16 1948

Registration District No. **132**

Primary Registration District No. **3021**

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

1. PLACE OF DEATH:
(a) County **GRUNDY**
(b) City or town **TRENTON**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
COLLERS Hosp. **D**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME **KATIE KATHERN ELVERT**
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex **FEMALE** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **H.A. ELVERT**
6. (c) Age of husband or wife if alive **78** years
7. Birth date of deceased **OCT 13 1866**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	81	11	19	hr. min.

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

10. Usual occupation **WIFE**

11. Industry or business _____

12. Name **ELIJAH MORRISON**

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

14. Maiden name **JENNIE F. WALKER**

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

16. (a) Informant **H.A. ELVERT**

(b) Address **SPICKARD MO.**

17. (a) **BURIAL** (b) Date thereof **OCT 3 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MARTIN CEM. GRUNDY CO. MO.**

18. (a) Signature of funeral director **G.C. HOOPER FUNERAL HOME**

(b) Address **SPICKARD MO.**

19. (a) **10-3-48** (b) **June Jaw**
(Date received local registrar) (Registrar's signature) **115**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Grundy 49**
(c) City or town **Spickard**
(If outside city or town limits, write "RURAL.")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **2**
year **1948** hour **1** minute **15** A.M.

21. I hereby certify that I attended the deceased from **June 15 1948** to **Oct. 2 1948**;
that I last saw her alive on **Oct 1 1948**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Interstitial nephritis**
Secondary anemia

Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings:
Of operations _____
Of autopsy **1310**

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? **0**

While at work? _____ (Specify type of place)
(c) Means of injury _____

23. Signature **Loft Collers** (M. D. _____)
Address **Trenton Mo** Date signed **10-2-48**

Duration **Four years**
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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 *Ross Wise*

Licensed Embalmer No. 3771

P. O. Address *Spickard 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.