

FILED MAR 11 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4254

| | | | | | | | | |
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| BIRTH NO. _____ | | REG. DIST. NO. <u>55</u> | | PRIMARY REG. DIST. NO. <u>3011</u> | | Registrar's No. <u>20</u> | | |
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Carroll</u> | | | | |
| b. CITY OR TOWN <u>Carrollton</u> | | c. LENGTH OF STAY (in this place) <u>50 yrs</u> | | c. CITY OR TOWN <u>Carrollton</u> | | d. STREET ADDRESS (If rural, give location) <u>0</u> | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bales Hosp. 0</u> | | | | | | | | |
| 3. NAME OF DECEASED (Type or Print) <u>ANDERSON</u> | | | a. (First) | | b. (Middle) <u>-</u> | | c. (Last) <u>ELLIS</u> | |
| 4. DATE OF DEATH <u>2-27-49</u> | | (Month) | | (Day) | | (Year) | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | | 8. DATE OF BIRTH <u>Mar. 6, 1860</u> | | |
| 9. AGE (in years last birthday) <u>88</u> | | IF UNDER 1 YEAR Months | | IF UNDER 1 YEAR Days | | IF UNDER 1 YEAR Hours | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Mechanic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Oil Co</u> | | 11. BIRTHPLACE (State or foreign country) <u>Mo. 0</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | |
| 13a. FATHER'S NAME <u>Unknown</u> | | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 14. NAME OF HUSBAND OR WIFE <u>Sally Bitzberg</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. _____ | | 17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Henry Losh</u> ADDRESS <u>Carrollton, Mo</u> | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Trochar of right hip, into transverse sinus</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Spinal Stenosis</u> DUE TO (c) <u>Procurvum Hydrocephalus</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2-21-49</u> <u>2-26-49</u> | | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u> | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Carrollton, Carroll Mo</u> | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>2 21 49 AM</u> | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <u>Fell on ice.</u> | | <u>19</u> | | |
| 22. I hereby certify that I attended the deceased from <u>Feb 21</u> , 19 <u>49</u> , to <u>Feb 27</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Feb 29</u> , 19 <u>49</u> , and that death occurred at <u>9:00</u> m., from the causes and on the date stated above. | | | | | | | | |
| 23a. SIGNATURE <u>Erigena Bales M.D.</u> (Degree or title) | | | | 23b. ADDRESS <u>Carrollton, Mo</u> | | 23c. DATE SIGNED <u>3-1-49</u> | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>3-1-49</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cem</u> | | 24d. LOCATION (City, town, or county) (State) <u>Carrollton Mo</u> | | |
| DATE REC'D BY LOCAL REG. <u>3/1/49</u> | | REGISTRAR'S SIGNATURE <u>Mrs Barbara Calvert</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Stanley Huber</u> ADDRESS <u>Carrollton Mo</u> | | | | |

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

RECEIVED
District Health Officer No. 8,
District File Number 3-10-49
Date Filed _____

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 _____

working under my personal supervision.

Student Embalmer No. _____

Signed Ben W. Gibson

Signed _____
Student Embalmer

Licensed Embalmer No. 2961

P. O. Address Carrollton, Ga.

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.