

FILED MAY 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11412**

BIRTH NO. _____ REG. DIST. NO. **4** PRIMARY REG. DIST. NO. **4086** Registrar's No. **23**

1. PLACE OF DEATH a. COUNTY Atchison		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Atchison	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Tarkio		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Tarkio	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION **			

3. NAME OF DECEASED (Type or Print) a. (First) SARAH ELLAN ELLSWORTH b. (Middle) c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) April 14, 1949		
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Sept 9, 1882	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months 7 Days 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME John Coon	13b. MOTHER'S MAIDEN NAME Katherine Barnes	14. NAME OF HUSBAND OR WIFE Edward Ellsworth
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Edward Ellsworth	ADDRESS Tarkio, Mo.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro-vascular accident		INTERVAL BETWEEN ONSET AND DEATH 3 days 10 days 33 4X
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio-sclerosis, cerebral		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 1)
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22. I hereby certify that I attended the deceased from **4-10**, 1949, to **4-14**, 1949, that I last saw the deceased alive on **4-14**, 1949, and that death occurred at **9:10 pm** from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title) M.D.	23b. ADDRESS Tarkio, Missouri.	23c. DATE SIGNED 4/16/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 4/17/49	24c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery	24d. LOCATION (City, town, or county) (State) Galt, Missouri
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DATE REC'D BY LOCAL REG. 4-17-49	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS Davis Funeral Home Tarkio, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEB 17 1961

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.....

..... Student Embalmer No.

working under my personal supervision.

Signed.....

John M. Davis
Licensed Embalmer No. 2394

Signed.....
Student Embalmer

P. O. Address..... Tarkio, 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.