

FILED JUN 30 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18735

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>43</u>		PRIMARY REG. DIST. NO. <u>3007</u>		Registrar's No. <u>221</u>	
1. PLACE OF DEATH <u>Brandon Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
a. COUNTY <u>Butler</u>		a. STATE <u>Mo</u>		b. COUNTY <u>Wayne</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Poplar Bluff, Mo.</u>		c. LENGTH OF STAY (in this place) <u>9 hrs. 10 minutes</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Patterson</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Brandon Hospital</u>				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH				
a. (First) <u>Charles</u>	b. (Middle) <u>Dwight</u>	c. (Last) <u>Ellis</u>	(Month) <u>June</u>	(Day) <u>22</u>	(Year) <u>1949</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Child</u>	8. DATE OF BIRTH <u>June 21/49</u>		9. AGE (In years last birthday)	IF UNDER 1 YEAR Months <u>18</u> Days <u>30</u>	IF UNDER 24 HRS. Min. <u>18</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Patterson Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Am.</u>	
13a. FATHER'S NAME <u>Charles J. Ellis</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Goforth</u>		14. NAME OF HUSBAND OR WIFE <u>&lt;</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>&lt;</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Charles J. Ellis Patterson Mo</u>			
18. CAUSE OF DEATH		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Respiratory failure</u>				<u>8:10 p.m.</u>	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES					
		Congenital malformation of respiratory tract.					
		DUE TO (b) <u>Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last.</u>					
		DUE TO (c) <u>Premature birth</u>				<u>7:15 a.m.</u>	
		II. OTHER SIGNIFICANT CONDITIONS				<u>7615</u>	
		Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>					
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>--</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>-</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>--</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>8:10 p.m.</u>			
22. I hereby certify that I attended the deceased from <u>6:20 a.m.</u> , <u>1949</u> , to <u>8:10 p.m.</u> , <u>1949</u> , that I last saw the deceased alive on <u>June 20, 1949</u> , and that death occurred at <u>8:10 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>E. N. Lockett, M.D.</u>				23b. ADDRESS <u>Brandon Hospital, 1124 N. Main Street, Poplar Bluff, Missouri.</u>		23c. DATE SIGNED <u>6-21-49</u>	
24a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>6/23/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Woods</u>		24d. LOCATION (City, town, or county) (State) <u>Wayne Co. Mo</u>		
DATE REC'D BY LOCAL REG. <u>6-24-49</u>		REGISTRAR'S SIGNATURE <u>Wm. H. Johnson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Cochr Piedmont</u>			

(Licensed Embalmer's Statement on Reverse Side)

mo.

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

JUN 27 RECD

BUTLER COUNTY HEALTH CENTER

649-148

**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 \_\_\_\_\_

*Cochran Funeral Home*

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed *William Cochran*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. *3723*

P. O. Address *Piedmont, 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.