

FILED SEP 9 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25997**

BIRTH NO. _____ REG. DIST. NO. 2 PRIMARY REG. DIST. NO. 5014 Registrar's No. 362

1. PLACE OF DEATH a. COUNTY <u>Andrew</u>		2. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buch.</u>	
b. CITY OR TOWN <u>Rural-Jefferson</u>		c. CITY OR TOWN <u>St. Joseph</u>	
c. LENGTH OF STAY (In this place) <u>year</u>		d. STREET ADDRESS (If rural, give location) <u>1005 East Hyde Park Avenue</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Hi-way on 71 hi-way</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Ella</u> b. (Middle) <u>Lee</u> c. (Last) <u>Elliott</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 28, 1949</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 9, 1917</u>	9. AGE (In years last birthday) <u>32</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>St. Joseph, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13a. FATHER'S NAME <u>William McIntyre</u>	13b. MOTHER'S MAIDEN NAME <u>Kate Porter</u>	14. NAME OF HUSBAND OR WIFE <u>Dwight Vincent Elliott</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. <u>unk</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Kate McIntyre-</u> ADDRESS <u>St. Joseph, Mo.</u>

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Concussion</u> ANTECEDENT CAUSES DUE TO (b) <u>Blow to Skull</u> DUE TO (c) <u>Automobile accident.</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Fractured right femur</u>		INTERVAL BETWEEN ONSET AND DEATH <u>85234</u> <u>32</u>
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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.) <u>U.S. Highway</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Andrew Mo.</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Aug. 28, 1949 8:05 p.m.</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Automobile accident. RORU02</u>

22. I hereby certify that I attended the deceased from Aug. 28, 1949, to Aug. 28, 1949, that I last saw the deceased alive on _____, 19____, and that death occurred at 8:05 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>W. B. Maxwell, M.D., Coroner</u>	23b. ADDRESS <u>307. W. Main, Swanton, Mo.</u>	23c. DATE SIGNED <u>8/28/49</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Aug. 28, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Ashland Cemetery</u>
24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>		

DATE REC'D BY LOCAL REG. <u>8-28-49</u>	REGISTRAR'S SIGNATURE <u>Lillian Spack</u>	FUNERAL DIRECTOR'S SIGNATURE <u>Stamey Funeral Home</u> ADDRESS <u>Stamey Funeral Home - St. Joseph, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

SEP 2 1948

DEC 2 1948
JUN 9 1950



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.

Student
Student Embalmer

Signed Charles M. Farman

Licensed Embalmer No. 4487

P. O. Address St. Joseph

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.