

FILED OCT 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29148

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>1</u>		PRIMARY REG. DIST. NO. <u>3000</u>		Registrar's No. <u>301</u>	
1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Adair</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kirksville</u>		c. LENGTH OF STAY (In this place) <u>Life</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Kirksville</u>		MISSOURI 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Laughlin Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>808 1/2 E. Harrison St.</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>BERT</u>		b. (Middle)		c. (Last) <u>ELSEA</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>9-30-49</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>May 19, 1881</u>	
9. AGE (In years last birthday) <u>68</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>11</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Adair Co., Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Will Elsea</u>		13b. MOTHER'S MAIDEN NAME <u>Molly Elsea</u>		14. NAME OF HUSBAND OR WIFE <u>Iva Summers Elsea</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>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Bert Elsea 808 1/2 E. Harrison St. Kirksville, 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>Peritonitis</u> ANTECEDENT CAUSES Due to (b) <u>ruptured and gangrenous gall bladder</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Cardiac lesion with mitral and systolic stenosis-pulmonary stasis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>536X</u>	
19a. DATE OF OPERATION <u>9-26-49</u>		19b. MAJOR FINDINGS OF OPERATION <u>Cholecystectomy, distended with stones, gangrenous and ruptured with peritonitis</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-26-49</u> 19 <u>49</u> , to <u>9-30-49</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>9-30-49</u> , 19 <u>49</u> , and that death occurred at <u>8:06 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Bert Elsea</u> (Degree or title) <u>D.O.</u>				23b. ADDRESS <u>Kirksville, Mo.</u>		23c. DATE SIGNED <u>10-5-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10-2-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Green Grove Cemet.</u>		24d. LOCATION (City, town, or county) (State) <u>Novinger, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>10-7-49</u>		REGISTRAR'S SIGNATURE <u>Walter Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Louis Funeral Home, Kirksville, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED OCT 10 1949
District Health Officer No. 10
District File Number 10-49-173
Date Filed OCT 10 1949

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 Clarence M. Billo

Signed _____
Student Embalmer

Licensed Embalmer No. 4375

P. O. Address Keokuk, 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.