

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20036**

FILED JUL 10 1950

BIRTH NO. _____ REG. DIST. NO. **143** PRIMARY REG. DIST. NO. **4232** Registrar's No. **44**

1. PLACE OF DEATH a. COUNTY Howell		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Howell	
b. CITY (If outside corporate limits, write RURAL and give township) Willow Springs TOWN Willow Springs		c. CITY (If outside corporate limits, write RURAL and give township) TOWN Willow Springs	
c. LENGTH OF STAY (in this place) 10 yrs		d. STREET ADDRESS (If rural, give location) July # 27 8460	
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) David b. (Middle) E c. (Last) Elliot		4. DATE OF DEATH (Month) (Day) (Year) June 25 1950	
5. SEX M	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug 2 1867
9. AGE (In years) (Month) (Day) (Hour) (Min.) 82		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maquon Ill		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Nettie		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Nettie ADDRESS	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Stomach		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		151X	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) _____	
DUE TO (c) _____		19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	

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 **May 14, 1950**, to **June 20, 1950**, that I last saw the deceased alive on **June 20, 1950**, and that death occurred at **10 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Garrett Kopp		23b. ADDRESS Cabool Mo		23c. DATE SIGNED June 26/50	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE June 28-50		24c. NAME OF CEMETERY OR CREMATORY Pine Grove		24d. LOCATION (City, town, or county) (State) Howell Co. Mo	
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DATE REC'D BY LOCAL REG. 6-29-50		REGISTRAR'S SIGNATURE Marshall Ballard		38 F. FUNERAL DIRECTOR'S SIGNATURE Gaylord V. Elliott ADDRESS Cabool Mo	
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 7-8-50

District Health Officer No. 5,

District File Number 750-774

Date Filed ONETT, MISSOURI

7-8-50

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 _____

Raymond W. Ellis

Licensed Embalmer No. 2252

P. O. Address Capool

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.