

FILED SEP 28 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29299**

BIRTH NO. _____ REG. DIST. NO. **1** PRIMARY REG. DIST. NO. **4001** Registrar's No. **252**

0010
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Adair	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Novinger		c. LENGTH OF STAY (in this place) Life	
d. FULL NAME OF HOSPITAL OR INSTITUTION Novinger, Mo.		d. STREET ADDRESS (If rural, give location) 0	

3. NAME OF DECEASED (Type or Print)	a. (First) Ezra	b. (Middle) L.	c. (Last) Elsworth	4. DATE OF DEATH (Month) (Day) (Year) Sept. 13, 1950
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 18, 1895	9. AGE (In years last birthday) 55	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner	10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	11. BIRTHPLACE (State or foreign country) Adair County, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Elmer Elsworth	13b. MOTHER'S MAIDEN NAME Mary Jacobs	14. NAME OF HUSBAND OR WIFE Edna May Baker
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown). (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Mrs. Edna Elsworth, Novinger, Mo.	ADDRESS _____
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Venular Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 5 years
	- ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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"/>	

21a. ACCIDENT SUICIDE HOMICIDE (Specify) no	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) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from **1940** to **Sept 13, 1950**, that I last saw the deceased alive on **Sept 12, 1950**, and that death occurred at **1:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE N. Harrison M.D. (Degree or title)	23b. ADDRESS Novinger, Mo.	23c. DATE SIGNED Sept 15-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9-16-50	24c. NAME OF CEMETERY OR CREMATORY Novinger,	24d. LOCATION (City, town, or county) (State) Novinger, Missouri
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DATE REC'D BY LOCAL REG. 9-16-50	REGISTRAR'S SIGNATURE Kate Lambert	25. FUNERAL DIRECTOR'S SIGNATURE Paul McRiley	ADDRESS Kirksville, Mo.
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SFP 29 1950

Date Received: SEP 25 1950
DISTRICT HEALTH OFFICE #
District File Number 9-50-
Date Filed: SEP 26 1950

Handwritten scribbles and illegible text

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

Glen A. Gibbons

working under my personal supervision.

Student Embalmer No.

Signed *Glen A. Gibbons*

Signed.....
Student Embalmer

Licensed Embalmer No. 4624

P.O. Address Kirksville, Mo.

52 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.