

FILED NOV 22 1950

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. 37727

0610

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

BIRTH NO. _____		REG. DIST. NO. <u>9</u>		PRIMARY REG. DIST. NO. <u>5740</u>		Registrar's No. <u>84</u>	
1. PLACE OF DEATH a. COUNTY <u>Macon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>"Rural" Lingo twp.</u>		c. LENGTH OF STAY (in this place) <u>8 weeks</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>New Cambria</u>		0610 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>5 miles S. of New Cambria</u>				d. STREET ADDRESS (If rural, give location) <u>XXXX</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Cora</u> b. (Middle) <u>Elizabeth</u> c. (Last) <u>Rose</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 30, 1950</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>Aug. 18, 1879</u>	
9. AGE (In years last birthday) <u>71</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>12</u>		IF UNDER 1 HR. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>General Store</u>		11. BIRTHPLACE (State or foreign country) <u>London Mills, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13a. FATHER'S NAME <u>Alexander T. McElhanev</u>			13b. MOTHER'S MAIDEN NAME <u>Ella Flowers</u>		14. NAME OF HUSBAND OR WIFE <u>L.T. Rose</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>xxx-496-24-4486</u>		17. INFORMANT'S SIGNATURE OR NAME. ADDRESS <u>Mrs. Katie Hayes New Cambria, 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>Cancer of Rectum</u>  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.  <u>54X</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Supplied</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Cancer of Rectum</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)		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>Sept 15, 1950</u> , to <u>Oct 30, 1950</u> , that I last saw the deceased alive on <u>Oct 30, 1950</u> , and that death occurred at <u>2 a. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Josephine King</u> (Degree or title)				23b. ADDRESS <u>New Cambria Mo.</u>		23c. DATE SIGNED <u>Oct 31, 50</u>	
24a. BURIAL, CREMATION) REMOVAL (Specify) <u>burial</u>		24b. DATE <u>Nov. 11, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>London Mills</u>		24d. LOCATION (City, town, or county) (State) <u>London Mills, Illinois</u>	
DATE REC'D BY LOCAL REG. <u>11/1/50</u>		REGISTRAR'S SIGNATURE <u>Josephine King</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H.P. Hilliard</u>		ADDRESS <u>New Cambria Mo.</u>	

RECEIVED 11.16.50  
MACON COUNTY HEALTH DEPARTMENT  
County File No. 11.50.811  
Date Filed 11.21.50

Date Received: NOV 14 1950  
DISTRICT HEALTH OFFICE #2  
District File Number  
Date Filed:

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 *H. J. Gilleland*

Licensed Embalmer No. 4019

P. O. Address *New Cambria 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.