

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7257**

FILED MAR 9 - 1953

BIRTH NO. _____ REG. DIST. NO. **314** PRIMARY REG. DIST. NO. **6059** Registrar's No. **7**

1. PLACE OF DEATH a. COUNTY St. Clair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY St. Clair	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Collins Twp.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Collins Twp. 0930	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) Humansville	

3. NAME OF DECEASED (Type or Print) a. (First) Florence b. (Middle) Elliott c. (Last) Elliott			4. DATE OF DEATH (Month) (Day) (Year) 2-16-53		
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5. SEX Fe	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 20 1903	9. AGE (In years last birthday) 49	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and State or Foreign Country) Downs Kansas	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME J. R. Clark	13b. MOTHER'S MAIDEN NAME Jane Hudson	14. NAME OF HUSBAND OR WIFE Ora Elliott
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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)	16. SOCIAL SECURITY NO. -	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ora Elliott Humansville, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) CONGESTIVE HEART FAILURE		MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CONGESTIVE HEART FAILURE		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4341		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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 **Feb 16** 1953, to **Feb 16** 1953, that I last saw the deceased alive on **Feb 16** 1953, and that death occurred at **10:00 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) D. B. A. Barton D.O.	23b. ADDRESS Collins Mo.	23c. DATE SIGNED Feb 16, 1953
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 2-16-53	24c. NAME OF CEMETERY OR CREMATORY Ottawa, Kansas	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. 2-16-1953	REGISTRAR'S SIGNATURE Ruth Seavers	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Beckwith Funeral Home Humansville
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 O. H. Beckwith

Licensed Embalmer No. 3937

P. O. Address Humansville, 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.