

FILED AUG 23 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26816

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>793</u>	
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Springfield</u>		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Rogersville Rural</u>		0390 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Handley Hosp.</u>				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) <u>IDA</u>			b. (Middle) <u>MAY</u>		c. (Last) <u>Elliott</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>AUG. 17 1954</u>
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>MAY 27, 1874</u>	
9. AGE (In years last birthday) <u>80</u>		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>St. Clair Co, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Mathis Burkhart</u>		13b. MOTHER'S MAIDEN NAME <u>M^{rs} Kibbin</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</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>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Grace Easthand, Rogersville, 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congestive Heart Failure</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) _____ E9031 20				INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Fracture of left hip</u>						<u>1 week</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Country farm</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>North Campbell Twp. Greene</u>		<u>039</u> Mo.	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Aug 10, 1954</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Just fell.</u>			
22. I hereby certify that I attended the deceased from <u>Aug 10</u> , 1954, to <u>Aug 17</u> , 1954, that I last saw the deceased alive on <u>Aug 17</u> , 1954, and that death occurred at <u>5:00 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Carl D. Russell</u>				23b. ADDRESS <u>1951 S. National Ave</u>		23c. DATE SIGNED <u>8-18-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bury in</u>		24b. DATE <u>Aug. 21, 1954</u>		24c. NAME OF CEMETERY OR CREMATORIA <u>OAK Grove Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Collins Missouri</u>	
DATE REC'D BY LOCAL REG. <u>8-20-54</u>		REGISTRAR'S SIGNATURE <u>Freith Williams</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H. C. Ferrell, Rogersville, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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 _____

working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed *Max G Miller*

Licensed Embalmer No. *4720*

P. O. Address. *Fairland Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.