No. 300
10.48

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 29 1955

State File No. 29329

BIRTH NO. _____ REG. DIST. NO. 86 PRIMARY REG. DIST. NO. 4149 Registrar's No. 27-1955

1. PLACE OF DEATH
a. COUNTY: Crawford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cuba
c. LENGTH OF STAY (In this place): Life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): AT Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Missouri
b. COUNTY: Crawford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cuba
d. STREET ADDRESS (If rural, give location): 0280

3. NAME OF DECEASED (Type or Print)
a. (First): Durward
b. (Middle): LYNN
c. (Last): Ellis

4. DATE OF DEATH (Month) (Day) (Year): Sept. 24-1955

5. SEX: male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married
8. DATE OF BIRTH: October 11, 1952
9. AGE (In years last birthday): 2 — If under 1 year: Months 11, Days 13; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10b. KIND OF BUSINESS OR INDUSTRY: AT Home
11. BIRTHPLACE (City and State or Foreign Country): Owensville, Mo.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Durward C. Ellis
13b. MOTHER'S MAIDEN NAME: Marie Evans
14. NAME OF HUSBAND OR WIFE: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: Mrs Marie Davis
ADDRESS: Cuba, Mo

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Circulatory Collapse — Interval between onset and death:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Viral Pneumonitis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. 492X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 24, 1955, *to* Sept 24, 1955, *that I last saw the deceased alive on* Sept 24, 1955, *and that death occurred at* 5:30 pm., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): F.A. Skellinger DO
23b. ADDRESS: Cuba Mo.
23c. DATE SIGNED: Sept 26, 55

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept 24, 1955
24c. NAME OF CEMETERY OR CREMATORY: Kinder Cemetery
24d. LOCATION (City, town, or county) (State): Cuba Mo.

DATE REC'D BY LOCAL REG.: 9-27-55
REGISTRAR'S SIGNATURE: Jane A. Shannon
FUNERAL DIRECTOR'S SIGNATURE: Norman R. Glover
ADDRESS: Cuba, Mo

(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 _____

_____, Student Embalmer No. _____,

working under my personal supervision.

Student _____
Student Embalmer

Signed Harrison A. Haener

Licensed Embalmer No. 4673

P. O. Address Cuba, Missouri

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.