

FILED DEC 13 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **37992**
5096

BIRTH NO.		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No.	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY <u>Jackson</u>		b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas</u>		a. STATE <u>Kansas</u>		b. COUNTY <u>Miami</u>	
c. LENGTH OF STAY (in this place) <u>33 DAYS</u>		c. CITY OR TOWN <u>Fontana</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Luke's Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>8150</u>			
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH			5. SEX	
a. (First) <u>Clarence</u>	b. (Middle) <u>L</u>	c. (Last) <u>Ellsworth</u>	(Month) <u>11</u>	(Day) <u>23</u>	(Year) <u>56</u>	M	6. COLOR OR RACE <u>W</u>
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
		<u>10-22-94</u>		<u>62</u>		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Pontiana, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Albert S. Ellsworth</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Shinkle</u>		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>514-16-7863</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Albert Ellsworth, Jr. Pontiana, Mo.</u>			
18. CAUSE OF DEATH		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic pyelonephritis</u>				<u>over 3 yrs</u>	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES					
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
		DUE TO (b)					
		DUE TO (c)				<u>6000</u>	
		II. OTHER SIGNIFICANT CONDITIONS					
		Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic peritonitis</u>				<u>3 days</u>	
19a. DATE OF OPERATION <u>Nov 18, 56</u>		19b. MAJOR FINDINGS OF OPERATION <u>Chronic peritonitis</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (Min)		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>Oct 20, 1956</u> , to <u>Nov 23, 1956</u> , that I last saw the deceased alive on <u>Nov 23, 1956</u> , and that death occurred at <u>4:15 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Andrew D. Mitchell M.D.</u>				23b. ADDRESS <u>Play Time Bldg, KC Mo</u>		23c. DATE SIGNED <u>11-23-56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>11/23/56</u>		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <u>Paola Kansas</u>	
DATE REC'D BY LOCAL REG. <u>11-24-56</u>		REGISTRAR'S SIGNATURE <u>newa minshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Stine + M^oClure K.C. Mo.</u>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
Andrew D. Mitchell

Wilson

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.....
Signature of Student Embalmer

Signed.....
J. H. Crowell

Licensed Embalmer No. *490*

P. O. Address.....
H. C. Me...

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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