

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED SEP 16 1957

30885

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 964

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death.) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Joseph</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL <b>No. Meth. Hosp.</b> INSTITUTION		Length of stay in 1b <b>1 day</b>	d. STREET ADDRESS (If outside, give location) <b>127 W. Valley</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Dana</b> Middle <b>Ellis</b> Last <b>Ellis</b>	4. DATE OF DEATH Month <b>Aug.</b> Day <b>28</b> Year <b>1957</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 27, 1957</b>	9. AGE (In years last birthday) <b>1</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b>	IF UNDER 24 HRS. Hours <b>1</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (City and state or country) <b>St. Joseph, Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>John Ellis</b>	13b. MOTHER'S MAIDEN NAME <b>Ida Mae Overman</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>John Ellis, St. Joseph, Mo</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral anoxia</b>	INTERVAL BETWEEN ONSET AND DEATH <b>19 1/2 hrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Bilateral complete pulmonary atelectasis</b> DUE TO (c) <b>7694<sup>12</sup></b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes mellitus; Hypertensive C.V. disease; Pre-ecthymosis; Gross obesity</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of it.)
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20c. TIME OF INJURY Hour <b>12:30</b> Month, Day, Year <b>8/27/57</b> a.m. p.m.
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20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>St. Joseph, Mo</b>	COUNTY <b>Buchanan</b>	STATE <b>Mo</b>
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21. I attended the deceased from <b>8/27/57</b> to <b>8/28/57</b> and last saw him alive on <b>8/28/57</b> Death occurred at <b>12:30</b> P. M. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>A. C. Kellerman MD</b>	22b. ADDRESS <b>St. Joseph Mo.</b>	22c. DATE SIGNED <b>8/30/57</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8/30/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rouse Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Darlington Mo</b>
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24. FUNERAL DIRECTOR <b>John Rupp</b>	ADDRESS <b>St. Joseph, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>Sept 3, 1957</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Robert Fulton</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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, ~~by~~ ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer.

Signed *John E. Camp* .....  
Licensed Embalmer No. *3986* .....  
P. O. Address *St. Joseph* .....

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.