

Health,  
& Welfare  
Public  
Service

FILED DEC 3 - 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41193

STATE FILE NUMBER

Registration District No. 226 Primary Registration District No. 4338 Registrar's No. 4

S. 300  
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>MONROE</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>MONROE</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>MONROE CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>MONROE CITY R.1</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ELLIS HOSPITAL</b>		Length of stay in lb <b>5 Hours</b>	d. STREET ADDRESS <b>R.F.D.1</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>GERALYN</b> Middle <b>DENISE</b> Last <b>ELLIOTT</b>			4. DATE OF DEATH Month <b>NOV</b> Day <b>25</b> Year <b>1957</b>		
5. SEX <b>FEMALE</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>NOV 25, 1957</b>		9. AGE (In years last birthday) IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <b>5</b> Min. <input type="checkbox"/>
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		11. BIRTHPLACE (City and state or country) <b>MONROE CITY, MO</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>DELBERT ELLIOTT</b>		13b. MOTHER'S MAIDEN NAME <b>DELOROS YATES</b>	
14. NAME OF HUSBAND OR WIFE		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>Delbert Elliott</b>		Address <b>Monroe City Mo R.1</b>			
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>Anencephalus with Craniorachischisis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>5 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					<b>750X</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in Part I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 item 18.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 COUNTY STATE	
21. I attended the deceased from <b>11/25/57</b> to <b>11/25/57</b> and last saw her alive on <b>11/25/57</b> Death occurred at <b>6:40 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Harold F. Ellis, D.O.</b>			22b. ADDRESS <b>Monroe City, Missouri</b>		22c. DATE SIGNED <b>11/26/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>11-26-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST STEPHENS CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>MONROE CITY, R.F.D.1 MO</b>
24. FUNERAL DIRECTOR <b>Wilson &amp; Sox</b>		ADDRESS <b>Monroe City Mo</b>		25. DATE RECD. BY LOCAL REG. <b>11-26-57</b>	26. REGISTRAR'S SIGNATURE <b>E. L. Robertson</b>

MEDICAL CERTIFICATION

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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 Ma....., Student Embalmer No..... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed Leticia L. Wilson.....

Licensed Embalmer No. 3014.....

P. O. Address MONROE CITY, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting;

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