

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-033599
STATE FILE NUMBER

FILED SEP 22 1958 Registration District No. 241 Primary Registration District No. 4360 Registrar's No. 26

300
1-57

1. PLACE OF DEATH a. COUNTY <u>NEW MADRID</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>NEW MADRID</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>PORTAGEVILLE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>PORTAGEVILLE</u> 0721
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b	d. STREET ADDRESS (If outside, give location). Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>WILLIAM</u> Last <u>ELLIS</u>			4. DATE OF DEATH Month <u>AUG.</u> Day <u>27</u> Year <u>1958</u>	
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 25 1872</u>	9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED CARPENTER</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>OHIO COUNTY - KENTUCKY</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>THEODORE ELLIS</u>	13b. MOTHER'S MAIDEN NAME <u>ATTIE CHAPMAN</u>	14. NAME OF HUSBAND OR WIFE
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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) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>Mrs. Tom Girvin</u> Address <u>PORTAGEVILLE, MO.</u>
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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) <u>acute coronary occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>4201</u>		INTERVAL BETWEEN ONSET AND DEATH <u>instantaneous</u> <u>10-15 years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Senile psychosis in acute manic state</u>		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.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT WORK <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	COUNTY	STATE
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21. I attended the deceased from May '58 to Aug 26, '58 and last saw her alive on Aug 26 '58
Death occurred at approximately 5:00 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>James A. Grable, M.D.</u>	22b. ADDRESS <u>Portageville, Mo.</u>	22c. DATE SIGNED <u>9/28/58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>8-28-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PORTAGEVILLE CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>PORTAGEVILLE, MO.</u>
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24. FUNERAL DIRECTOR <u>DELISLE FUNERAL PARLOR</u>	ADDRESS <u>PORTAGEVILLE MO</u>	25. DATE RECD. BY LOCAL REG. <u>8-29-58</u>	26. REGISTRAR'S SIGNATURE <u>Ellen W. Lisle Mulem</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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DATE RECEIVED SEP 16 1958
NEW MADRID CO. HEALTH CENTER

P. J. L.

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 James A. DeFude
Licensed Embalmer No. 4481

P. O. Address PORTA G. U. L. L. E. Y

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.