

Health, Welfare, Public Service

8

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010348
STATE FILE NUMBER

Registration District No. 972 Primary Registration District No. 4398 Registrar's No. 21

1. PLACE OF DEATH a. COUNTY <u>Genissee</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Genissee</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hallond</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Hallond</u> <u>0786</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Life</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>Life</u>
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Stanley</u> Middle <u>Joe</u> Last <u>Ellieatt</u>			4. DATE OF DEATH Month <u>3</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-16-59</u>	
9. AGE (In years last birthday) Months <u>2</u> Days <u>3</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chill</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Columbia Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Pete Ellieatt</u>		13b. MOTHER'S MAIDEN NAME <u>Betty Cannon</u>		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) <u>NO</u>	16. SOCIAL SECURITY NO. <u> </u>	17. INFORMANT <u>Pete Ellieatt</u> Address <u>Hallond 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>C. C. A.</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____		
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.		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 5 Mar 59 to 3/19/59 and last saw ^{him} him alive on 5 Mar. 59
Death occurred at A on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Karen Bartlett</u> (Degree or title) <u>D.O. 2</u>	22b. ADDRESS <u>St. Louis, Mo.</u>	22c. DATE SIGNED <u>21/19/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE <u>3-19-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT Zion</u>	23d. LOCATION (City, town, or country) (State) <u>St. Louis Mo</u>
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24. FUNERAL DIRECTOR <u>Superior Mort Co. St. Louis Mo</u>	25. DATE RECD. BY LOCAL REG. <u>3-26-59</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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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.

1939
COUNTY HEALTH DEPARTMENT
CITY HOUSE PHONE 79
CARUTHERSVILLE, MO.

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 Not Embalmed, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed

Licensed Embalmer No.....

P. O. Address.....

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.