

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-016343  
STATE FILE NUMBER

AMENDED  
Registration District No. 4 Primary Registration District No. 4014 Registrar's No. 57

FILED MAY 31 1961

1. PLACE OF DEATH a. COUNTY <b>Atchison</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Atchison</b>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fairfax</b>		Length of stay in 1b <b>20 days</b>	c. CITY OR TOWN <b>Tarkio</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Fairfax Community Hosp</b>		Inside Limits No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>#</b> Last <b>ELLSWORTH</b>			4. DATE OF DEATH Month <b>May</b> Day <b>2</b> Year <b>1961</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12/29/1873</b>	9. AGE (last birthday) <b>87</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>3</b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ret'd farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own farm</b>		11. BIRTHPLACE (City and state or country) <b>Modena, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S</b>
13a. FATHER'S NAME <b>Jacob Ellsworth</b>		13b. MOTHER'S MAIDEN NAME <b>Susan Jane Vanderpool</b>		14. NAME OF HUSBAND OR WIFE <b>Sarah</b>		
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>Wilbur Ellsworth Tarkio, Mo.</b> Address		

18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Circulatory collapse</b>		<b>1 hour</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Leg Amputation</b>	<b>30 hours</b>
	DUE TO (c) <b>Arterial Occlusive Disease</b>	<b>3 mos</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Gangrene Foot, Anticoagulant Discrepancy</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 <b></b> a.m. <b></b> p.m. <b></b> Month, Day, Year <b></b>				

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 **April 12, 1961** to **May 2, 1961** and last saw him alive on **May 2, 1961**  
Death occurred at **7:45p.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Decree or title) <b>Edward S. Bann M.D.</b>	22b. ADDRESS <b>Tarkio, Mo.</b>	22c. DATE SIGNED <b>5/3/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>5/4/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Odds Fellows Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Galt, Missouri</b>
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24. FUNERAL DIRECTOR <b>Davis Funeral Home</b>	ADDRESS <b>Tarkio, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>5/12/1961</b>	26. REGISTRAR'S SIGNATURE <b>Charlene J. Schaefer</b>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**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 Frost A. Browning

Licensed Embalmer No. 3338

P. O. Address Tarkio, 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.