DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15949

Registration District No. 772 Primary Registration District No. 4463 Registrar's No. 945

1. PLACE OF DEATH:

(a) County St Francois

(b) City or town Elvins Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Home. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 (Specify whether years, months or days) In this community 7 years.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Francois

(c) City or town E Lynn (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME William Kellum

3. (b) If veteran, name war — 3. (c) Social Security No.

4. Sex Male | 5. Color or race White | 6. (a) Single, widowed, married, divorced V

6. (b) Name of husband or wife V — 6. (c) Age of husband or wife if alive years

7. Birth date of deceased 2 (Month) 23 (Day) 1864 (Year)

8. AGE: Years	Months	Days	If less than one day
76	6	26	hr. min.

9. Birthplace Ill. (City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business

FATHER
12. Name Leo Kellum
13. Birthplace Ill. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace Catherine Hoffner (City, town, or county) (State or foreign country)

16. (a) Informant's own signature [illegible]
(b) Address Elvins Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-19-40 (Month) (Day) (Year)
(c) Place: burial or cremation Old Hill

18. (a) Signature of funeral director Sparks Bud Co
(b) Address Elvins Mo

19. (a) 4-18-40 (Date received local registrar) (b) B Barrar (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 18 day April year 1940 hour 2:30 minute P M.

21. I hereby certify that I attended the deceased from 4-18-38 to 4-18, 1940; that I last saw him alive on 4-1-'40, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Paralysis Agitans	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature B Barrar (M. D. or ~~other~~)
Address Flat River Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....
H. Murphy & Sparks, Registered Apprentice No. 241
working under my personal supervision.

Signed. Ewert Sparks

Licensed Embalmer No. 2639

P. O. Address. Elmira 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 this body is not embalmed, above space should be left blank.

No. 2B
2-21-40
X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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Registration District No. 772

Primary Registration District No. 4463

Registrar's No.

1. PLACE OF DEATH:

(a) County St Francois

(b) City or town Elvins
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits write "RURAL")

(d) Street No.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Wm Kellums

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Louisa Kellums

6. (c) Age of husband, or wife, if alive 72 years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 76 | Months 11 | Days 26 | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 4/20/40 (Date received by local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 18 day 4

year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;

that I last saw h alive on , 19 ;

and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically.

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(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature G. B. Farmer (M. D. or other)

Address Flat River Mo Date signed

SUPPLEMENTARY