LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH
County: Marion
Township: ~~Marion~~
or
Village:
or
City: Hannibal (No. 617 Collier St. 3 Ward)

Registration District No. 547
Primary Registration District No. 3029

File No. 14580
Registered No. 134

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME: Martain Alfred Ellis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M
4 COLOR OR RACE: C
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Not Known (Month) (Day) 1850 (Year)

7 AGE: 69 yrs. mos. ds.
If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (City or town, State or foreign country): Mo

PARENTS
10 NAME OF FATHER: Martain Ellis
11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Mo
12 MAIDEN NAME OF MOTHER: Not Known
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): " "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Jane Ellis
(Address): 617 Collier St

15
Filed 4-21-, 1919. F. B. Morris, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 18 (Day), 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from 1918, 191..., to April 18, 1919, that I last saw h— alive on April 17, 1919, and that death occurred, on the date stated above, at 11 30 P.M.

The CAUSE OF DEATH* was as follows:
131
Chronic Bright's Disease
120
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) F. B. Meek M. D.
4-21, 1919 (Address) 121 Church

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Hannibal Mo
DATE OF BURIAL: 4/21, 1919

20 UNDERTAKER: [illegible]
ADDRESS: Hannibal

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MISSOURI STATE BOARD OF HE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township..... Registration District No..... File No.....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City..... (NO..... St.;..... Ward)

[If death occ
hospital or
give its NAM
of street and

2 FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... 1.....
(Month) (Day) (Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work.....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address).....

15

Filed..... 191..... .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... 19
(Month) (Day)

17 I HEREBY CERTIFY, that I attended deceas

....., 191....., to.....,

that I last saw h.....alive on.....,

and that death occurred, on the date stated above, at.....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....

CONTRIBUTORY .....
(Secondary)

..... (Duration).....yrs.....mos.....

(Signed).....

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Ca
(1) Means of Injury; and (2) whether Accidental, Suicidal or H

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tr
or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL

20 UNDERTAKER	ADDRESS