Fract Mann

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

Do not use this space.

1919

1. PLACE OF DEATH
County Lafeyette
Township
City Napoleon (No. ..... St. ..... Ward)

Registration District No. 466
Primary Registration District No. 4276

File No.
Registered No. 1

2. FULL NAME William Britt Ellis
(a) Residence. No. ..... St., ... Ward. (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M M
4. COLOR OR RACE White Wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Katherine Ellis Napoleon

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 26 1878

7. AGE YEARS 51 MONTHS 11 DAYS 21 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED Coal Miner
(a) Trade, profession, or particular kind of work Coal Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Jackson County
(STATE OR COUNTRY) mo

PARENTS
10. NAME OF FATHER Ferdinand Ellis
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kansas Terry
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Sarah Murray
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Tenn
(STATE OR COUNTRY)

14. INFORMANT Dorathy Ellis
(Address) Napoleon Mo.

15. FILED Jan 17 1931 F. W. Mann REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan-16 1931

17. I HEREBY CERTIFY, That I attended deceased from Jan 14th, 1931, to Jan 16th, 1931 that I last saw he alive on Jan 16th, 1931 and that death occurred, on the date stated above, at 10 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apendicitis
121B
129 (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (SECONDARY) Peritonitis
(duration) ..... yrs. ..... mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) F. W. Mann, M. D.
Jan 17, 1931 (Address) Wellington Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Buckner Mo. DATE OF BURIAL Jan-18 1931

20. UNDERTAKER V. M. Reppert ADDRESS Buckner Mo

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

5-2-11-20

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Lafayette — Registration District No. 466 — File No. .....

Township ..... — Primary Registration District No. 4276 — Registered No. 1

City Napoleon (No. ....., ... St. ..... Ward)

2. FULL NAME William Britt Ellis

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 26-1878

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
X	52 X	11	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED ....., 19 F. W. Mann X
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 16 19 31

17. I HEREBY CERTIFY, That I attended deceased from ..... 19 ..... to ..... 19 ..... that I last saw h..... alive on ..... 19 ....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-1919