

N. B.—Every item of information should be carefully supplied. AGE MUST 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.

18 1939

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

31372  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Jackson 1 Registration District No. 399  
 (b) Township Kaw Primary Registration District No. 1002  
 (c) City Kansas City (d) Street No. 2927 Wabash Registered No. 3470  
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
 (e) 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.)

2. PRINT FULL NAME Eliza Ethel Ellison  
 (a) Residence, No. 2927 Wabash St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OR RACE wh. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 23-1887

7. AGE YEARS 57 MONTHS 7 DAYS 9 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None  
 9. Industry or business in which work was done, as saw mill, bank, etc. None  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Virginia

FATHER 13. NAME Dr. Wm. Akers  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Vir.

MOTHER 15. MAIDEN NAME Helen  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

17. INFORMANT (ADDRESS) Mrs. Carl George  
2600 Euclid

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Washington DATE Sept 6 1939

19. FUNERAL DIRECTOR (ADDRESS) Cedar Funeral Home  
N. S. W.

20. FILE NO. 1939 M. M. Grome  
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 3 1939

22. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, 19\_\_\_\_  
 I last saw him/her live on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
 The principal cause of death and related causes of importance were as follows:  
Carcinoma of the sigmoid  
& metastases 46  
 Date of onset \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) Victor H. Miller M. D.  
 (Address) K.C. Mo.

STATEMENT BY LICENSED EMBALMER

I, Chas Wilks, Licensed Embalmer No. 2644

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

.....L. E. ....

No.....or by.....Registered Apprentice No.....

working under my personal supervision.

Signed Chas Wilks

Licensed Embalmer No. 2644

**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.)**