EMFA JUN 17 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17670

Registration District No. 399 | Primary Registration District No. 1002 | Registrar's No. 2197

1. PLACE OF DEATH:

(a) County: Jackson

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

(c) Name of hospital or institution: 421½ Westport Road
(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: 20 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson

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

(d) Street No.: 421½ Westport Road
(If rural, give location)

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

3. (a) PRINT FULL NAME: John C. Elledge 432

3. (b) If veteran, name war: World War

3. (c) Social Security No.:

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife: —

6. (c) Age of husband or wife if alive: — years

7. Birth date of deceased: January 9, 1887 (Month) (Day) (Year)

8. AGE: Years 53 | Months 4 | Days 18 | If less than one day ____ hr. ____ min.

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

10. Usual occupation: Mechanical engineer

11. Industry or business:

FATHER
12. Name: James D. Elledge
13. Birthplace: Illinois (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Nancy Scott
15. Birthplace: Don't Know (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. John Elledge
(b) Address: 4044 Baltimore

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 29, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation: XXXXXWadsworth, Kansas

18. (a) Signature of funeral director: Freeman Mortuary
(b) Address: 104 W. 42nd St., K.C., Mo.

19. (a) May 29, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 28, year 1940 hour 5:05 minute A. M.

21. I hereby certify that I attended the deceased from Chronic ____, 19____;
that I last saw h____ alive on ____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic myocardial fibrosis — Duration
Due to: Chronic pelvicitis
Due to: ——— 9 yrs
Other conditions (Include pregnancy within ~~3 months of death~~):

Major findings: Of operations: ———
Of autopsy: Surgeon

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: [illegible] (M. D. or other) 5/29/40
Address: [illegible] Date signed: ____

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 2939

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.