

REG 16 1940 194
Registration District No.

Primary Registration District No. 3011

Registrar's No. 172

1. PLACE OF DEATH:

(a) County CLAY
(b) City or town EXCELSIOR SPRINGS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
434 CONCOURSE AVE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution X
(Specify whether years, months or days) 30 yrs. 2

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CLAY
(c) City or town EXCELSIOR SPRINGS
(If outside city or town limits, write "RURAL")
(d) Street No. 434 CONCOURSE AVE
(If rural, give location)
(e) If foreign born, how long in U. S. A.? X years.

3. (a) PRINT FULL NAME ANNA ECTON

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

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE

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

7. Birth date of deceased MEB. 26 1881
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
59 8 26 Y hr. Y min.

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

10. Usual occupation AT HOME

11. Industry or business 0

MOTHER FATHER { 12. Name THOMAS B. ECTON 0

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

14. Maiden name IRA J. DOURSEY

15. Birthplace UNKNOWN MO
(City, town, or county) (State or foreign country)

16. (a) Informant Elmer Ecton Kemp
(b) Address Excelsior Springs Mo.

17. (a) Burial (b) Date thereof 11-24-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crown Hill
18. (a) Signature of funeral director Herbert Hoops
(b) Address Excelsior Springs Mo.

19. (a) 11-23-40 (b) Maria M. Cracken
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 22nd
year 1940 hour 11 minute 05 P.M.

21. I hereby certify that I attended the deceased from 9-26-
1940 to 11-22 1940
that I last saw her alive on 11:05 PM - Nov 22nd 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Pancreas
and Stomach

Due to X
Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings:
Of operations _____
Of autopsy _____

Duration

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? CRN

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

23. Signature [Signature]
Address Excelsior Springs, Mo. Date signed 11-23-40

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

46

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 12-14-21

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 Virgil Hope

Licensed Embalmer No. 3950

P. O. Address Excelsior Springs

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **38472**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **198**

Primary Registration District No. **3011**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **Ray**
(b) City or town **Exelsior Springs**
(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)
In this community _____ (Specify whether)
years, months or days

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 **Anna Ecton**

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

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **8**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

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

8. AGE: Years **59** Months **8** 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 _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Nov** day **22** year **1940** hour _____ minute _____ M.

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

Immediate cause of death **Cerebral hemorrhage and stomach perforation**
Due to **Cerebral hemorrhage of stomach - perforation**

Other conditions (Include pregnancy within 3 months of death) **46**

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? _____

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

23. Signature _____ (M. D. or other)

Address _____ Date _____

Exelsior Springs Mo.

SUPPLEMENTARY

