

Registration District No. 328

Primary Registration District No. 5462

Registrar's No.

1. PLACE OF DEATH:

(a) County Grundy
 (b) City or town Lincoln
 (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 _____
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME Joyce Ellis

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased Jan. 1 1941
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
 2 hr. min.

9. Birthplace Grundy Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Leland Ellis

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

14. Maiden name Martha Avery

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

16. (a) Informant Leland Ellis

(b) Address Spickard, Mo.

17. (a) Burial (b) Date thereof: 3-2-41
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bethel

18. (a) Signature of funeral director Walter Funeral Home

(b) Address Princeton, Mo.

19. (a) 3-2-41 (b) Joyce S. Fair
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Grundy
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. So. of Spickard, Mo.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb 1 day 1
 year 1941 hour 9 A.M. minute _____ M.

21. I hereby certify that I attended the deceased from Feb 28
 1941 to Feb 28, 1941

that I last saw her alive on Feb 28, 1941
 and that death occurred on the date and hour stated above.

Immediate cause of death Broncho Pneumonia

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 E. W. Ewing (M. D. or other) 0

Address Spickard Mo Date signed _____

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

MOTHER FATHER

107

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.....

Not Embalmed

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

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. 17907

Registration District No. 328

Primary Registration District No. 5462

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Greene, T.P.
(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 _____
years, months or days

3. (a) PRINT FULL NAME Joyce Ellis
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 Child

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 _____ Months 2 Days _____ 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)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov day 1
year 1994 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho pneumonia
Due to no complications

Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)
107

Major findings:
Of operations _____
Of autopsy _____

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 EW Ewing (M. D. or other) _____
Address Spur Road Mo Date signed 11/24/94

SUPPLEMENTARY

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

MOTHER FATHER

Duration 5 days
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

S-17907

1950
1951
1952
1953
1954
1955
1956
1957
1958
1959
1960