

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

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.

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

34469
Do not use this space.

FILED OCT 27 1941

1. PLACE OF DEATH *Old well*

(a) County *Old well* Registration District No. *94*

(b) Township *Breckenridge* Primary Registration District No. *4-0-5-5-40-56* Registered No. *0*

(c) City *Breckenridge* (d) Street No. *1* (If death occurred in Hospital or Institution, write its name instead of street and number) St. *0*

(e) Length of residence in city or town where death occurred *76* yrs. mos. da. (If How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME *Ella Ellsworth Wilson*

(a) Residence, No. *Breckenridge mo* St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *married*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *July 9 1862*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *79 11 21*

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *House wife*

9. Industry or business in which work was done, as saw mill, bank, etc.

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) *Columbus, Ind*

FATHER 13. NAME *Nelson Miller*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Grantport Ky*

MOTHER 15. MAIDEN NAME *Lettie Simon*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ind*

17. INFORMANT (ADDRESS) *Mary E Wilson Breckenridge mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Wesley Hill* DATE *Oct 2 1941*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *J. M. Beets Breckenridge mo*

20. FILED *Sept 30 1941 A. R. Hurley mo* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept 30 1941*

22. I HEREBY CERTIFY, That I attended deceased from *Sept 23 1941* to *Sept 30 1941*

I last saw *her* alive on *Sept 30 1941*. Death is said to have occurred on the date stated above, at *4 P. m.*

The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage

Date of onset *Sept 1 1941*

Other contributory causes of importance: *g30*

Name of operation *none* Date of *F*

What test confirmed diagnosis? *clinical* Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? *none* Date of injury *19*

Where did injury occur? *F* (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury *F*

Nature of injury *F*

24. Was disease or injury in any way related to occupation of deceased? *no*

If so, specify (Signed) *E. A. Thompson*, M. D. (Address) *Breckenridge mo*

20

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.....

T. H. McBeck

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

working under my personal supervision.

Signed *T. H. McBeck*

Licensed Embalmer No. *1570*

P. O. Address *Brockersville MD*

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, above space should be left blank.