

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 11 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

1179

State File No. _____

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 40

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: St. Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1/27/41 to 1/6/42 (Specify whether
In this community 1 month years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Kansas (b) County Franklin
(c) City or town Wellsville (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.? 2 years.

3. (a) PRINT FULL NAME Ellis, Mrs. Sam J
3. (b) If veteran, name war No 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 1 day 6
year 42 hour 4:30 minute A.M.

4. Sex Female! 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mr. Sam J. Ellis 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased April 15 1901
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 12/7, 1941, to 1/6, 1942,
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death Generalized Abnormal Punctate Petechias

8. AGE: Years 40 Months 8 Days 21 If less than one day
_____ hr. _____ min.

Due to Chronic Salpingitis organ undisturbed
Due to F
Other conditions Presence of the Cervix
(Include pregnancy within 3 months of death)

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) Gardner Hs. (b) Date thereof Jan-6 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director H. G. Patterson
(b) Address Gardner Hospital

19. (a) Jan 4 1942 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

Major findings: Chronic Salpingitis - Punctate Petechias
Of operations _____
Of autopsy Abnormal

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) (2) Means of injury _____

23. Signature Spaulding (M. D. or other)
Address _____ Date signed _____

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

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.....

P. O. Address.....

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.

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STANDARD CERTIFICATE OF DEATH

State File No.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registrar's No. 40

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County
(b) City or town
(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) 6

3. (a) PRINT FULL NAME Mrs Marie Ellis

3. (b) If veteran, name war 3. (c) Social Security No. none

4. Sex 5. Color or race 6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife Sam Ellis 6. (c) Age of husband, or wife, if alive 50 years

7. Birth date of deceased. (Month) (Day) (Year)
8. AGE: Years Months Days If less than one day hr. min.

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

10. Usual occupation Housework

11. Industry or business own home

12. Name Jacob Aderegge

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

14. Maiden name Anna Speithberger

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

16. (a) Informant Sam Ellis

(b) Address Wellsville Kas

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address 114/42 N. M. Crow

19. (a) 1/4/42 (b) (Registrar's signature) (Date received local registrar)

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.

20. DATE OF DEATH Month Jan day 6 year 1942 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

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 (M. D. or other)

Address Date signed.....

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

PRELIMINARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-1179