S. No. 2

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 24 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10080

Registration District No. 24 | Primary Registration District No. 4021 | Registrar's No.

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

1. PLACE OF DEATH:

(a) County: Barry

(b) City or town: Cassville, Mo. Rt # 2. Twp

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

(c) Name of hospital or institution: ~~at her~~ Cassville Rt #2.

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 1 (Specify whether years, months or days)

In this community: all her life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Barry 005

(c) City or town: Rural. 0

(If outside city or town limits, write "RURAL")

(d) Street No.: Cassville Rt # 2.

(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country: 0

3. (a) PRINT FULL NAME: Mildred Dora Elliott

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: Female 1

5. Color or race: White

6. (a) Single, ~~widowed~~, married, ~~divorced~~: Single 0

6. (b) Name of husband or wife:

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

7. Birth date of deceased: February (Month) 8 (Day) 1918 (Year)

8. AGE: Years 24 | Months 1 | Days 4 | If less than one day: hr. min.

9. Birthplace: Cassville (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation:

11. Industry or business:

FATHER

12. Name: C. H. Elliott

13. Birthplace: Lebanon Co. (City, town, or county) Kansas (State or foreign country)

MOTHER

14. Maiden name: Effie Lester

15. Birthplace: Jasper Co. (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant: C. H. Elliott

(b) Address: Cassville, Mo. Rt # 2.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3-13-1942 (Month) (Day) (Year)

(c) Place: burial or cremation: Oak Ridge Cem.

18. (a) Signature of funeral director: Koon Funeral Home

(b) Address: Cassville, Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 12th year 1942 hour 10 minute 45 A.M.

21. I hereby certify that I attended the deceased from Jan, 1942 to Mar 8, 1942 that I last saw her alive on Mar. 8, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Endocarditis

Due to:

Due to: 9 | C

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?

While at work: (Specify type of place) (e) Means of injury: 0

23. Signature: Glenn N. Dalyer (M. D. ~~or other~~)

Address: Cassville Mo. Date signed:

1077 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 442-597
Date Filed APR 23 1942

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.

No. 2B
—8-21-41
X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10080

Registration District No. 29 Primary Registration District No. 4021 Registrar's No.

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

1. PLACE OF DEATH:
(a) County: Barry
(b) City or town: Rural
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME: Mildred V. Elliott
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: S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive
7. Birth date of deceased: Feb (Month) 8 (Day) 1918 (Year)
8. AGE: Years 24 Months 1 Days 28 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) Mar 26, 1942 (Date received local registrar) Grace Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar Day 12 year 1942 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.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

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)
(b) 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

SUPPLEMENTARY