

No. 2
9-4-41
7-39
X29484

State File No.

FILED AUG 7 1943
Registration District No.

Primary Registration District No. 6058

Registrar's No. 11

1. PLACE OF DEATH:

(a) County St. Clair
(b) City or town Leury City Rural (Shawnee)
(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 10 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Clair
(c) City or town Leury City Rural
(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 Hanna Elliott

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

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

6. (b) Name of husband or wife Leuan Elliott 6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased 12 1 1888
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
54 7 0 hr. min.

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

10. Usual occupation House Wife

11. Industry or business _____

MOTHER FATHER

12. Name John W. George

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

14. Maiden name Margaret Brown

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

16. (a) Informant L. C. Elliott

(b) Address Leury City Mo.

17. (a) Removal (b) Date thereof 7 3 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City Kans.

18. (a) Signature of funeral director Walter Eckhoff

(b) Address Appleton City, Mo.

19. (a) 7-21-43 (b) W. E. Holt
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1
year 1943 hour 7 minute _____ M.

21. I hereby certify that I attended the deceased from July 1
1 1943 to July 1 1943
that I last saw h. _____ alive on none 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death unknown ✓

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) Means of injury _____

23. Signature R. L. Kansins (M. D. or other) MD
Address Appleton City Mo Date signed 7-2-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 7,

District File Number

7-43-712

Date Filed

8-4-43

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

Robert E. Bluff

Licensed Embalmer No.

3942

P. O. Address

Appleton City

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 312

Primary Registration District No. 10058

Registrar's No. 11

1. PLACE OF DEATH:

(a) County St Clair
(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 _____)

In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Hanna 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 m

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

7. Birth date of deceased see (Month) 1888 (Day) _____ (Year) _____

8. AGE: Years 54 Months 7 Days _____ If less than one day _____ 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) _____ (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 July year 1943 Day _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Cause unknown

Due to I saw her after death but never

Due to saw her before she died she probably died of

Other conditions heart failure (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)
(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 R L Hanson (M. D. or other) _____

Address Appleton City Date signed 8-12-43

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

SUPPLEMENTARY

200a

S-25924