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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

41918

State File No. 4-216

74761 8 JAN 1943
Registration District No. 574

Primary Registration District No. 5231

Registrar's No. 216

1. PLACE OF DEATH, Cass
(a) County
(b) City or town Rural Sherman Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 60 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED: 19
(a) State Missouri (b) County Cass
(c) City or town Rural Sherman Twp
(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. 0 years.

3. (a) PRINT FULL NAME MARY E. ELLIOTT
3. (b) If veteran, name war. 3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH, Month DECEMBER day TUESDAY
year 1943 hour 3.00 PM minute 00. P. M.
21. I hereby certify that I attended the deceased from DECEMBER
27th, 1943 to DECEMBER 28, 1943

4. Sex female 5. Color or race white
6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife Elliott 6. (c) Age of husband or wife If
alive years

that I last saw her alive on 12-27, 1943
and that death occurred on the date and hour stated above.
Immediate cause of death PASSIVE
PULMONARY CONGESTION
HYPERSTATIC PNEUMONIA.
Due to CARDIO-VASCULAR-RENAL
SYNDROME.

7. Birth date of deceased may 14 1847
(Month) (Day) (Year)
8. AGE: Years Months Days If less than one day
46 7 15 hr. min.

Due to ARTERIOSCLEROTIC
CHANGES & SENILITY.
Other conditions (Include pregnancy within 3 months of death)
Major findings: 1310
Of operations.
Of autopsy.

9. Birthplace Ind. / (City, town, or county) (State or foreign country)
10. Usual occupation House keeper
11. Industry or business
12. Name Jacob Clark
13. Birthplace Ireland (City, town, or county) (State or foreign country)
14. Maiden name Don't know
15. Birthplace 9 (City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Lewis Woods
(b) Address Brighton, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 30 1943
(Month) (Day) (Year)
(c) Place: burial or cremation Pamperton emetary
18. (a) Signature of funeral director J. M. Kauffman
(b) Address Garden City, MO.
19. (a) (Date received local registrar) (b) (Registrar's signature)

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?
23. Signature J. M. Kauffman (Specify type of plate) (M: D or other)
Address Garden City, MO Date signed 12/29/43

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

STATEMENT BY LICENSED EMBALMER

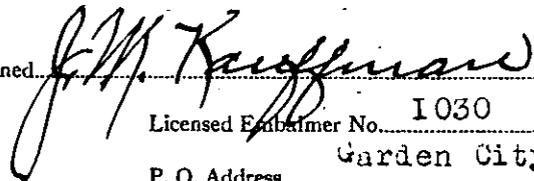
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

J.M. Kauffman

Registered Apprentice No. I 030

working under my personal supervision.

Signed.....



Licensed Embalmer No. I 030

P. O. Address Garden City, Mo.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan.
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County Cass
(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 _____ years, months or days)

3. (a) PRINT FULL NAME Mary E. Elliott
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year
7. Birth date of deceased May 14 (Month) (Day) (Year)

8. AGE: Years 96 Months 7 Days 28 If less than one day _____ min.
9. Birthplace Ind. (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 Pemberton Cemetery
18. (a) Signature of funeral director J. M. Karllman
(b) Address Garden City, Mo.
19. (a) Dec. 31, 1943 (b) Margaret Valle
(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 Dec. year 1943 day _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him _____ 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 _____

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

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

SUPPLEMENTARY

JUN 19 1944

5-41918