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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 12 1945

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 9838

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 66

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

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**1. PLACE OF DEATH:**

(a) County Jackson

(b) City or town Indep. Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Independence Sanitarium O (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 weeks (Specify whether

In this community 6 years (years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson

(c) City or town ~~Independence Mo~~ Rural (If outside city or town limits, write "RURAL")

(d) Street No. 1919 Home. (If rural, give location) 48

(e) Citizen of foreign country? No 1 (Yes or No)

If yes, name country

**3. (a) PRINT FULL NAME** Mrs Lucinda M. Blanche Ellis.

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 Widowed 9

6. (b) Name of husband or wife

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

7. Birth date of deceased Nov. (Month) 25 (Day) - 1866 (Year)

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 3 | 27 | hr. min. |

9. Birthplace Bedford, Co. (City, town, or county) Va. 1 (State or foreign country)

10. Usual occupation House wife

11. Industry or business

FATHER
12. Name John Wesley Settle
13. Birthplace Bedford, Co. (City, town, or county) Va. 1 (State or foreign country)

MOTHER
14. Maiden name Nancy Mary Bandy
15. Birthplace Bedford, Co. (City, town, or county) Va. 1 (State or foreign country)

16. (a) Informant Ruch Stockdale

(b) Address 1220 W. Ruby, Indep Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 24-45 (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn Cemetery

18. (a) Signature of funeral director Ott & Mitchell

(b) Address 310 N. Main St. Indep. Mo

19. (a) 3-23-45 (Date received local registrar) (b) James W. Ross (Registrar's signature)

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month March day 22 year 1945 hour 2 minute 20 A M.

21. I hereby certify that I attended the deceased from Feby. 27, 1945 to March 1945 that I last saw her alive on March 21st 1945; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Pneumonia | 5 days |
| Due to Cerebral Hemorrhage | 30 days. |
| 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)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Chas. T. Grabske (M. D. or other)

Address Independence, Mo Date signed 3/21/45

116 3

(Licensed Embalmer's Statement on Reverse Side)

## 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 me

, Registered Apprentice No.

working under my personal supervision.

Signed Henry L. Mitchell

Licensed Embalmer No. 3925

P. O. Address Lindy 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, fact should be so stated above.**

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 12 1945

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 66

**1. PLACE OF DEATH:**

(a) County Jackson

(b) City or town Independence
(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)

**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 Lucinda M B Ellis

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 W

6. (b) Name of husband or wife

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

7. Birth date of deceased Nov. 25 1866
(Month) (Day) (Year)

8. AGE: Years 78 Months 3 Days 27 If less than one day: hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) (Date received local registrar) (b) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Mar 22
year 1945 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 Bronchial pneumonia

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature Chas H Grabing (M. D. or other)

Address Date signed

SUPPLEMENTARY

9838