

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29643
3799
Registrar's No. 3799

FILED SEP 25 1945

Registration District No. 179 Primary Registration District No. 1002

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

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 month
(Specify whether years, months or days)

In this community 6 years

3. (a) PRINT FULL NAME Isaac Ellis

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male 5. Color or race white

6. (a) Single, widowed, married, divorced, divorced

6. (b) Name of husband or wife Syla See 6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: Years 63 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace no (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation labour

11. Industry or business _____

12. Name William S Ellis

13. Birthplace no (City, town, or county) _____ (State or foreign country) _____

14. Maiden name Lincy Conrad

15. Birthplace no (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant Monroe Ellis

(b) Address 4000 Bales

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-13-45
(Month) (Day) (Year)

(c) Place: burial or cremation Hopeville, McCall, Mo

18. (a) Signature of funeral director Edna King

(b) Address Seaside, Mo

19. (a) 9-13-45 (Date received local registrar) (b) Heraldine Holmes (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 4000 Bales
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 13 year 1945 hour 3 minute 55 A. M.

21. I hereby certify that I attended the deceased from Aug 12, 1945, to Sept 13, 1945; that I last saw him alive on Sept 12, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure Duration _____

Due to Toxic effect of extensive emphysema

Due to Postoperative complications of closure of perforated duodenal ulcer

Other conditions 117 & 1
(Include pregnancy within 3 months of death)

Major findings: Of operations Perforated duodenal ulcer

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 F. L. Lippson (M. D. certifier)

Address Raytown, Mo Date signed 9/13/45

SEP 27 1945

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 *Quane Ewing*
Licensed Embalmer No. *3847*
P. O. Address. *Sedalia 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.