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1-238671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED APR 14 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **9892**  
Registrar's No. **46**

Registration District No. **187** Primary Registration District No. **3040**

1. PLACE OF DEATH:

(a) County **Livingston**  
(b) City or town **Chillicothe**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Chillicothe Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: **5 days** (Specify whether  
In this community years, months or days)

3. (a) PRINT FULL NAME **Lelo Ethel Ehrstein**

3. (b) If veteran, name war **--** 3. (c) Social Security No. **--**

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

6. (b) Name of husband or wife **James J. Ehrstein** 6. (c) Age of husband or wife if alive **47** years

7. Birth date of deceased **Sept 20, 1879**  
(Month) (Day) (Year)

8. AGE: Years **67** Months **6** Days **2** If less than one day hr. min.

9. Birthplace **Volga City Iowa**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

12. Name **Alva R. Campbell**

13. Birthplace **Volga City Iowa**  
(City, town, or county) (State or foreign country)

14. Maiden name **Watts**

15. Birthplace **Cleveland Ohio**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Morris Hatchett**

(b) Address **Ludlow, Missouri**

17. (a) **Burial** (b) Date thereof **3-29-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Monroe Center Cem.**

18. (a) Signature of funeral director **Demond Neal**  
**Braymer, Missouri**

(b) Address **3-29-47**

19. (a) **3-29-47** (b) **Frances B. Neill**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Livingston**  
(c) City or town **Ludlow**  
(If outside city or town limits, write "RURAL")  
(d) Street No. (If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar** day **27**  
year **1947** hour **6** minute **4** M.

21. I hereby certify that I attended the deceased from **Mar 22**  
19 **47** to **Mar 27** 19 **47**  
that I last saw her alive on **Mar 26** 19 **47**  
and that death occurred on the date and hour stated above.

Immediate cause of death

**Pulmonary Embolism**

Due to **Interochanteic fracture of left femur**

Other conditions **Diabetes Mellitus**  
(Include pregnancy within 3 months of death)

Major findings:

Of operations  
Of autopsy

PHYSICIAN  
ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED  
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 **J. M. Drivell** (M. D. or other)  
Address **Chillicothe Mo** Date signed **3/27/47**

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

MOTHER FATHER

APR 30 1947

071  
E-1A

**DISTRICT HEALTH OFFICE  
Cameron, Mo.**

**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..... 2801  
P. O. Address..... Braymer, Missouri.

**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. !**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. April  
Registrar's No. 76

Registration District No. 187 Primary Registration District No. 3040

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

1. PLACE OF DEATH:

(a) County Livingston  
(b) City or town Chillicothe  
(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 Leo E. Christman

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Sept 20 (Month) (Day) (Year)

8. AGE: Years 67 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day, hr. min.)

9. Birthplace Iowa (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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Burial, cremation, or removal) (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 April 27  
year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ 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 \_\_\_\_\_

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) Accident due to fall on home ✓  
(b) Date of occurrence 3/15/47  
(c) Where did injury occur? Home - Puller Av. - MO (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work? yes (Specify type of place) (a) Means of injury Fall

23. Signature B. M. Dowell (M. D. or other) \_\_\_\_\_  
Date signed \_\_\_\_\_

SUPPLEMENTARY

9892