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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 29 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 24743

Registration District No. 182 Primary Registration District No. 5686 Registrar's No. 19

1. PLACE OF DEATH:

(a) County Linn

(b) City or town Linneus Locust Creek Twp (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Linn County Infirmery (If not in hospital or institution, write street number or location)

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

In this community 68 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn 58

(c) City or town LaClede 0 (If outside city or town limits, write "RURAL")

(d) Street No. 0 (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME ELLA MAY ONG

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 Single

6. (b) Name of husband or wife

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

7. Birth date of deceased: August (Month) 29 (Day) 1862 (Year)

8. AGE: Years 84 Months 10 Days 12 If less than one day hr. min.

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

10. Usual occupation None

11. Industry or business

FATHER
12. Name John Lewis Ong
13. Birthplace Ongs Mill (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name Margaret Purviance
15. Birthplace Ongs Mill (City, town, or county) Illinois (State or foreign country)

16. (a) Informant Wesley Love
(b) Address Centerville Iowa

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 13 1947 (Month) (Day) (Year)
(c) Place: burial or cremation LaClede Cemetery

18. (a) Signature of funeral director McGharne
(b) Address LaClede Linn Co. Mo.

19. (a) July 16-47 (Date received local registrar) (b) Mrs Birdie Kelley (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month July day 11 year 1947 hour 10 minute A M.

21. I hereby certify that I attended the deceased from March 10, 1947, to July 5, 1947; that I last saw her alive on July 5, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Senility	—
Due to Cerebral Arteriosclerosis	6 yrs
Due to	
Other conditions Chronic Interstitial Nephritis (Include pregnancy within 3 months of death)	4 yrs

Major findings:
Of operations
Of autopsy

131B

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? 2 (Specify type of place)

While at work? (e) Means of injury

23. Signature Roy R. Haley (M. D. or other) Jeto

Address Brookfield Mo. Date signed 7/18/47

(Licensed Embalmer's Statement on Reverse Side)

DISTRICT HEALTH OFFICE
ST. JOSEPH, 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 me McShane, Registered Apprentice No. ..... working under my personal supervision.

Signed McShane

Licensed Embalmer No. 2876

P. O. Address Ladlede, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
—3-45
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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. [illegible]

Registration District No. 142 Primary Registration District No. 5686 Registrar's No. 197

1. PLACE OF DEATH:

(a) County: Linn

(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 years, months or days)
In this community

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: Ella May Eng

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: S

6. (b) Name of husband or wife

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

7. Birth date of deceased: Aug (Month) 29 (Day) 1926 (Year)

8. AGE: Years 84 Months 10 Days 4 If less than one day hr. min.

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

10. Usual occupation: None

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) Mrs Birdie Kelley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 11 year 1942 hour about 2 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 — Duration

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)
(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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-24743