

No. 2
5-43
17-39
X36671

FILED NOV 18 1947

Registration District No. **206** Primary Registration District No. **5757**

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

1. PLACE OF DEATH:

(a) County **Madison**

(b) City or town **Rural, St. Michael**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Rural Route #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **NONE** (Specify whether)

In this community **86 yrs.** (years, months or days)

3. (a) PRINT FULL NAME **William Joseph Ellis**

3. (b) If veteran, name war **NONE**

3. (c) Social Security No. **NONE**

4. Sex **MALE** 5. Color or race **White**

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

6. (b) Name of husband or wife **ANNIE ELLIS**

6. (c) Age of husband or wife if alive **75** years

7. Birth date of deceased **March 18, 1861**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	86	6	19	hr. min.

9. Birthplace **Madison Co. Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation: **Farmer**

11. Industry or business:

MOTHER FATHER

12. Name **Moses Ellis**

13. Birthplace **Madison Co. Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Duchouquet**

15. Birthplace **Madison Co. Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Genevieve Ellis**

(b) Address **R#1, Fredericktown, Mo.**

17. (a) **BURIAL** (b) Date thereof **10-9-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Fredericktown, Mo.**

18. (a) Signature of funeral director **James N. Jones**

(b) Address **Fredericktown, Mo.**

19. (a) **11-3-1947** (b) **Florence Wickes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Madison**

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

(d) Street No. **St. Michael Township, RR#1**
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **7** year **1947** hour **9** minute **A** M.

21. I hereby certify that I attended the deceased from **April** 19**46** to **Oct 7** 19**47**
that I last saw him alive on **Oct 6** 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **fractured hip** Duration **7 days**

sharped Arterio Sclerosis **years.**

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

Major findings:
Of operations **8/6 ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

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 **62**

(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 **W. Slaughter** (M. D. or other) _____
Address **Fredericktown, Mo.** Date signed **10/18/47**

RECEIVED

District Health Officer No. 4
District File Number 1147-1437
Date Filed 11-12-47

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 Sam Sajio, Jr.

Licensed Embalmer No. 4299

P. O. Address Fredericktown, 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.

Registration District No. 206

Primary Registration District No. 751

Registrar's No. 45-

1. PLACE OF DEATH:

(a) County Madison
 (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 William J. Ellis

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased March 18
(Month) (Day) (Year)

8. AGE: Years 86 Months 6 Days _____
(if less than one day)
 hr. _____ min. _____

9. Birthplace mo
(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 _____
 year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
 that I last saw him/her _____, 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
 (b) Date of occurrence Oct 3rd 1947
 (c) Where did injury occur? His Home
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home, Fall in the barrel
(Specify type of place)
 While at work? _____ (e) Means of injury _____

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

SUPPLEMENTARY

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

38883

to [unclear]