

S. No. 2  
OM-5-43  
v. 5-17-39  
I X36671

FILED FEB 24 1948

State File No. \_\_\_\_\_

Registration District No. 187

Primary Registration District No. 3040

Registrar's No. 21

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 Hosp  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 16 hrs.  
(Specify whether \_\_\_\_\_)

In this community 5 Mo.  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston

(c) City or town Collis  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME Amanda H. Ellis

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 9  
year 1948 hour 12 minute 30 P.M.

21. I hereby certify that I attended the deceased from Feb. 8 1948 to Feb. 8 1948  
that I last saw her alive on Feb. 7 1948  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased July 17 1864  
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage - Ponsalpis R. Side

Due to \_\_\_\_\_

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>6</u>	<u>22</u>	<u>-</u> hr. <u>-</u> min.

Due to \_\_\_\_\_

Other conditions: (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: \_\_\_\_\_

- Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

9. Birthplace \_\_\_\_\_  
(City, town, or county) Ohio  
(State or foreign country)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

10. Usual occupation At home

11. Industry or business \_\_\_\_\_

12. Name John Ruff

13. Birthplace \_\_\_\_\_  
(City, town, or county) Ohio  
(State or foreign country)

14. Maiden name Unknown

15. Birthplace \_\_\_\_\_  
(City, town, or county) 9  
(State or foreign country)

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? 0

16. (a) Informant Mrs. Bessie King

(b) Address Chillicothe, Missouri

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/9/48  
(Month) (Day) (Year)

(c) Place: burial or cremation Oseola, Mo.

23. Signature Joseph A. ... (M. D. or other) M. P.  
Address Chillicothe, Mo. Date signed Feb 9-48

18. (a) Signature of funeral director Woodrich Funeral Home  
(b) Address Oseola, Missouri

19. (a) Feb. 9-48 (Date received local registrar) (b) Francis B. Neill (Registrar's signature) 141

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

MOTHER FATHER

JUL 1 1948

**DISTRICT HEALTH OFFICE  
Cameron, Mo.**

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**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 *Ronald F. Gordon*

Licensed Embalmer No. *4191*

P. O. Address *Chillicothe, 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.**