

BIRTH NO. REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Kansas b. COUNTY Washington	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Washington	
c. LENGTH OF STAY (In this place) 6 MOS		d. STREET ADDRESS (If rural, give location) 200 No B Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1332 Monroe Ave			

3. NAME OF DECEASED (Type or Print) a. (First) ESTHER	b. (Middle) C	c. (Last) ELLIOTT	4. DATE OF DEATH (Month) (Day) (Year) 1 31 1956
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan 9, 1874	9. AGE (In years last birthday) 82	# UNDER 1 YEAR Months	YEAR Days	# UNDER 6 HRS. Hours	MIN.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (State or foreign country) Kansas	12. CITIZEN OF WHAT COUNTRY? U S A
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13a. FATHER'S NAME John Carter	13b. MOTHER'S MAIDEN NAME Mary Bowker	14. NAME OF HUSBAND OR WIFE Archilles Elliott
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME Mr Robert E Dobbins	ADDRESS 1332 Monroe KCMo
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	19. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5 days 6 Mo. not known 443X
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia		
	ANTECEDENT CAUSES DUE TO (b) Cerebral Hemorrhage Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) Hypertensive C-V disease		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 29, 1955, to Jan 31, 1956, that I last saw the deceased alive on Jan 21, 1956, and that death occurred at 2:00 am, from the causes and on the date stated above.

23a. SIGNATURE James E. McCormick M.D.	(Degree or title)	23b. ADDRESS 2025 Swift No. Kan City	23c. DATE SIGNED 1/31/56
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24. BURIAL, CREMATION, REMOVAL Removal	24b. DATE 1-31-1956	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Linn, Kansas
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DATE REC'D BY LOCAL REG. 1-31-56	REGISTRAR'S SIGNATURE neva minshall	25. FUNERAL DIRECTOR'S SIGNATURE Charles M. ...	ADDRESS Linn, Ks.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD James E. McCormick

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.....

.....
working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed.....
George A. Reising

Licensed Embalmer No. 4468

P. O. Address Kansas City, Kansas

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.