

TYPE/PRINT
IN
PERMANENT
BLACK INK.
FOR
INSTRUCTIONS
SEE OTHER SIDE
AND HANDBOOK.

FILED MAR 23 1988

MISSOURI DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

STATE FILE NUMBER

REGISTRATION DISTRICT NO. 069

REGISTRAR'S NUMBER

DELAYED 235005

124 - 57-047822

1. DECEDENT'S NAME (First, Middle, Last)

Mark Hanna Ellis

2. SEX

Male

3. DATE OF DEATH (Month, Day, Year)

July 13, 1957

4. SOCIAL SECURITY NO.

5a. AGE - Last
Birth (Years)

56

5b. UNDER 1 YEAR

MONTHS

DAYS

5c. UNDER 1 DAY

HOURS

MINUTES

6. DATE OF BIRTH (Month, Day, Year)

May 20, 1901

7. BIRTHPLACE (City and State or Foreign Country)

Bloomfield, Missouri

8. WAS DECEDENT EVER IN U.S. ARMED FORCES?

Yes No Unk.

8a. PLACE OF DEATH (Check only one; see instructions on other side)

HOSPITAL: Inpatient ER/Outpatient DOA OTHER: Nursing Home Residence Other (Specify)

9a. FACILITY NAME (If not institution, give street and number)

Dunklin County Memorial Hospital

9c. CITY, TOWN, OR LOCATION OF DEATH

Kennett

9d. COUNTY OF DEATH

Dunklin

10. MARITAL STATUS - Married, Never Married, Widowed, Divorced, (Specify)

Married

11. SURVIVING SPOUSE'S NAME (If wife, give full maiden name)

N/A

12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.)

Farmer

12b. KIND OF BUSINESS OR INDUSTRY

Row-Crop Farming

13a. RESIDENCE - STATE

Missouri

13b. COUNTY

Dunklin

13c. CITY, TOWN, OR LOCATION

Kennett

13d. ZIP CODE

63876

13e. STREET AND NUMBER

2007 Loyd Street

13f. INSIDE CITY LIMITS

Yes No

13g. YEARS AT PRESENT ADDRESS

Under 5 5-9 10-19 20 or more

14. WAS DECEDENT OF HISPANIC ORIGIN (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.)

No Yes Specify:

15. RACE - American Indian, Black, White, etc. (Specify)

White

18. DECEDENT'S EDUCATION (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+) N/A

17. FATHER'S NAME (First, Middle, Last)

Jim Ellis

18. MOTHER'S NAME (First, Middle, Maiden Surname)

Nora Brown

19a. INFORMANT'S NAME (Type/Print)

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. BURIAL, CREMATION, OTHER (Specify)

Burial

20b. DATE OF DISPOSITION (Month, Day, Year)

July 16, 1957

20c. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)

Oak Ridge Cemetery

20d. LOCATION - City or Town, State

Kennett, Missouri

21. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH

22a. NAME AND ADDRESS OF FACILITY
P.O. Box 188
McDaniel Funeral Service Senath, MO

22b. FUNERAL ESTABLISHMENT LICENSE NUMBER

188

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d. DUE TO (OR AS A CONSEQUENCE OF):

Approximate Interval Between Onset and Death

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS?

Yes No Unk.

25a. WAS AN AUTOPSY PERFORMED?

Yes No

25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

Yes No

26. MANNER OF DEATH

Natural Pending Investigation Accident Suicide Could not be Determined Homicide

27a. DATE OF INJURY (Month, Day, Year)

27b. TIME OF INJURY

M

27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent)

Yes No Unk.

27d. INJURY AT WORK?

Yes No Unk.

27e. DESCRIBE HOW INJURY OCCURRED

28a. (Specify)

CERTIFYING PHYSICIAN MEDICAL EXAMINER/CORONER

28b. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated.

(Signature and Title) ▶

28c. DATE SIGNED (Month, Day, Year)

28d. TIME OF DEATH

1:00 P. M

29a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER OR CORONER) (Type or Print)

Dr. Joe Zimmerman Teaco Rd, Kennett, MO

29b. MO. LICENSE NUMBER

30. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER?

Yes No

31. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

32. REGISTRAR'S SIGNATURE

33. DATE RECEIVED BY LOCAL REGISTRAR (Month, Day, Year)

DO NOT WRITE ON THIS STUB

7-cy	12a	23u	27g-co
9a	13e	23-sc1	29g-cy
9b	13b	27-sc2	29a
9c	14	27e-f	29b
12b	15	27g-st	

Notarized
A copy of funeral home
hospital records,
county
VS 300
MO 580
INSTRUCTIONS ON OTHER SIDE
of a funeral home
copy sent
in Dunklin
Filed on the basis
statements from the
records and a
PASSED AWAY 7/13/57

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 _____, Student Embalmer No. _____ working under my personal supervision.

Student _____ Signed _____
 Signature of Student Embalmer Licensed Embalmer No. _____

NAME OF DECEDENT Mark Hanna Ellis P.O. Address _____

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.

INSTRUCTIONS FOR SELECTED ITEMS

Item 9a - Place of Death

If the death was pronounced in a hospital, check the box indicating the decedent's status at the institution (inpatient, emergency room/outpatient, or dead on arrival (DOA). If death was pronounced elsewhere, check the box indicating whether pronouncement occurred at a nursing home, residence, or other location. If other is checked, specify where death was legally pronounced, such as a physician's office, the place where the accident occurred, or at work.

Item 13a-g - Residence of Decedent

Residence of the decedent is the place where he or she actually resided. This is not necessarily the same as "home state," or "legal residence." Never enter a temporary residence such as one used during a visit, business trip, or a vacation. Place of residence during a tour of military duty or during attendance at college is not considered as temporary and should be considered as the place of residence. If a decedent had been living in a facility where an individual usually resides for a long period of time, such as a group home, mental institution, nursing home, penitentiary, or hospital for the chronically ill, report the location of that facility in items 13a through 13g. If the decedent was an infant who never resided at home, the place of residence is that of the parent(s) or legal guardian. Do not use an acute care hospital's location as the place of residence for any infant.

Item 23 - Cause of Death

The cause of death means the disease, abnormality, injury or poisoning that caused the death, not the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. In Part I the immediate cause of death is reported on line (a). Antecedent conditions, if any, which gave rise to the cause are reported on lines (b), (c), and (d). The underlying cause should be reported on the last line used in Part I. No entry is necessary on lines (b), (c), and (d) if the immediate cause of death on line (a) describes completely the chain of events. ONLY ONE CAUSE SHOULD BE ENTERED ON A LINE. Additional lines may be added if necessary. Provide the best estimate of the interval between the onset of each condition and death. Do not leave the interval blank; if unknown, so specify. In Part II, enter other important diseases or conditions that may have contributed to death but did not result in the underlying cause of death given in Part I.

EXAMPLE OF PHYSICIAN CERTIFICATION:

IMMEDIATE CAUSE → <i>(Final disease or condition resulting in death)</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE <i>(disease or injury that initiated events resulting in death) LAST</i>	a.	Rupture of myocardium DUE TO (OR AS A CONSEQUENCE OF):		Approximate Interval Between Onset and Death Mins	
	b.	Acute myocardial infarction DUE TO (OR AS A CONSEQUENCE OF):		6 days	
	c.	Chronic ischemic heart disease DUE TO (OR AS A CONSEQUENCE OF):		5 years	
	d.				
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Diabetes, Chronic obstructive pulmonary disease, smoking</u>		24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	25a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	25 b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
26. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide	27a. DATE OF INJURY (Month, Day, Year)	27b. TIME OF INJURY M.	27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK.	27d. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK.	27e. DESCRIBE HOW INJURY OCCURRED
27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		27g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			

EXAMPLE OF MEDICAL EXAMINER OR CORONER

IMMEDIATE CAUSE → <i>(Final disease or condition resulting in death)</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE <i>(disease or injury that initiated events resulting in death) LAST</i>	a.	Cerebral laceration DUE TO (OR AS A CONSEQUENCE OF):		Approximate Interval Between Onset and Death	
	b.	Open skull fracture DUE TO (OR AS A CONSEQUENCE OF):		10 mins.	
	c.	Automobile accident DUE TO (OR AS A CONSEQUENCE OF):		10 mins.	
	d.				
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unk.	25a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	25 b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
26. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide	27a. DATE OF INJURY (Month, Day, Year) 11/15/85	27b. TIME OF INJURY 1 p.M.	27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27d. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unk.	27e. DESCRIBE HOW INJURY OCCURRED 2-car collision-driver
27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) Street		27g. LOCATION (Street and Number or Rural Route Number, City or Town, State) Route 4, Jefferson City, Missouri			