

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-043305

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 533 Primary Registration District No. 3074 Registrar's No. 230

FILED NOV 27 1961

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Mississippi</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Likeston</u>		Length of stay in 1b <u>11 days</u>	c. CITY OR TOWN <u>East Prairie</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Delta Community</u>		Inside limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>S. Washington</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Mollie</u> Middle <u>E</u> Last <u>Ell</u>			4. DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>61</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-31-86</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>17</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Bollinger County, Mo. USA</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>John L. Zimmerman</u>	13b. MOTHER'S MAIDEN NAME <u>Celia Solace</u>	14. NAME OF HUSBAND OR WIFE <u>Frank Ell</u>
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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)	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT Address <u>John Manuel, Raeford, N. Carolina</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure, intractable</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from 11-10-61 to 11-18-61 and last saw her alive on 11-18-61
Death occurred at 7:40 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>R. F. Mozier M.D.</u>	22b. ADDRESS <u>Charleston, Mo.</u>	22c. DATE SIGNED <u>11-23-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-19-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Blytheville Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Blytheville, Arkansas</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Travis Shelby, East Prairie, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11-23-1961</u>	26. REGISTRAR'S SIGNATURE <u>Jeanette Waldman</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

STATEMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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 _____
Signature of Student Embalmer

Signed Walter Shelby Jr.

Licensed Embalmer No. 4940

P. O. Address East Prairie, La.

No permit

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.