JUN 27 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

17114

1. PLACE OF DEATH
County St Charles Registration District No. 757
Township ~~Dardenne~~ St Charles Primary Registration District No. 3036
City ~~St Peters~~ St Charles St Jos Hospital St. Ward)

File No.
Registered No. 45

2. FULL NAME Anna Ell
(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF married Anton Ell
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 5-1867
7. AGE Years 63 Months 6 7 Days 26 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN) St Charles
(STATE OR COUNTRY) Mo
PARENTS
10. NAME OF FATHER Ferdinand Earnest
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Helen Bellers
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St Louis
(STATE OR COUNTRY) Mo
14. INFORMANT Alphonse Ell
(Address) St Peters Mo
15. FILED 6/2, 1930 Hy G. Blackburn
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 31 1930
17. I HEREBY CERTIFY, That I attended deceased from May 20, 1930, to May 31, 1930 that I last saw her alive on May 31, 1930 and that death occurred, on the date stated above, at 6 30 P m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bacillary Dysentery
138
131
(duration) yrs. mos. 14 ds.
CONTRIBUTORY (SECONDARY) Chronic Nephritis
(duration) Second mos. ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? NO DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J M Jenkins, M. D
, 19 (Address) St Charles, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL All Saints Cem.
DATE OF BURIAL June 4 1930
20. UNDERTAKER Hy Wahlhausen
ADDRESS St Peters Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
AGE should be stated EXACTLY. PHYSICIANS should state

5a. (5.29.-1)

BENEFICIARY AFFIDAVIT No. 4

Phoenix Mutual Life Insurance Company.

I hereby certify that Annie Ell the beneficiary named in
olicy No 174423 died at St Josephs Hosp St Charles on the 29 day of May
930 and that she was the mfe of Anton Ell, the insured
nder said policy.

Dated at St Charles Mo this 12 day of July 1930

J. M. Jenkins M.D.

114

ate of Missouri
unty of St Charles } ss.

On this 13th day of August 1930, before me, the undersigned, appeared
J. M. Jenkins M.D.
sonally known to me, and duly acknowledged the execution of the above instrument.

s.

J. Geo. Diehr Notary Public

N. B. This acknowledgement should be executed before a Notary Public or other officer using an official stamp seal, bearing his own name. Otherwise a certificate from the proper thority should be attached, showing that he is duly authorized to administer oaths.

icate on the reverse side should be executed.

1930 5 29
67 11 5
62 6 24

Certificate of the official registrar or person having charge of the official or public records.

I hereby Certify, *that I have examined the Records of Deaths in* .....

..... *and find recorded therein in Register No.* ..... *page* ..... *th*

death of ....., *age* .....

If there is no official registrar, a certificate should be obtained from the attending physician.

date of death ....., *cause of death* .....

..... *and that said record was made on the* ..... *day o*

..... 1 , *from the certificate of Dr.* .....

attending Physician.

Seal of Office.

.....

S 17114 (2)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County ..... Registration District No. 757 ..... File No. .....

Township ..... Primary Registration District No. 3036 ..... Registered No. 95

City St. Charles (No. ..... St. ..... Ward)

2. FULL NAME Ama Ell

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	W	M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov-5-1867

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
62	X	6	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED 6/2 1930 Hy. G. Blochaum
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 29 1930

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19..., that I last saw h..... alive on ..... 19..., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
	19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

...y item of information should ... carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... state CAUSE OF DEATH in plain terms, so that it ... properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-17114 (2)