

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

NOV 13 1939 791  
Registration District No. 1000

Primary Registration District No. \_\_\_\_\_

Registrar's No. 8429

1. PLACE OF DEATH: 1

(a) County Mo.

(b) City or town ST LOUIS.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: FIRMIN DESLOCIE HOSPITAL.  
(If not in hospital or institution, write street number or location)

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

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 1

(c) City or town ST LOUIS. 12  
(If outside city or town limits, write "RURAL")

(d) Street No. 786. A AUBERT AVE  
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME JAMES. FISKE. ELLIS. H&O

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

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

4. Sex MALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED.

6. (b) Name of husband or wife FLORA. ELLIS. 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased AUG. 22. 1865  
(Month) (Day) (Year)

8. AGE: Years 74. Months 1 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation PRINTER.

11. Industry or business GLOBE DEMOCRAT. O

12. Name HENRY. B. ELLIS. O

13. Birthplace MO. 1  
(City, town, or county) (State or foreign country)

14. Maiden name ARATHA. MADIAR.  
(City, town, or county) (State or foreign country)

15. Birthplace LA.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature [Signature]  
(b) Address 786. AUBERT. AVE

17. (a) BURIAL. (b) Date thereof 10-3-39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LAKE CHARLES.

18. (a) Signature of funeral director L. M. Mullen.  
(b) Address 5765 DELMAR BLVD.

19. (a) OCT 2 1939 (b) [Signature]  
(Date received local health officer's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sep day 30 year 1939 hour 3 minute 30 P. M.

21. I hereby certify that I attended the deceased from Sep 29, 1939, to Sep 30, 1939; that I last saw him alive on Sep 30 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration 2 days

Due to Hypertensive Cardiac Vascular Disease 2 yrs

Due to [Signature]

Other conditions auricular fibrillation  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

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

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 1

28. Signature Ralph Kusella (M. D. or other) \_\_\_\_\_  
Address A 15 Beaumont Date signed 10/2/39

Dr. Kinsella  
3730 Washington  
JE 5100

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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 John Ketter  
Licensed Embalmer No. 3880  
P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**