

No. 2
11-10-39
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

23803

State File No. _____

6248

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

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

(c) Name of hospital or institution: 3834 Sullivan **2**
(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

3. (a) PRINT FULL NAME Ellie Gleason **425**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color of race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: May 1, 1867
(Month) (Day) (Year)

8. AGE: Years 73 Months 2 Days 24 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Pat Cremin **5**

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

14. Maiden name Ellen England **5**

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

16. (a) Informant John Gleason

(b) Address 3834 Sullivan

17. (a) Burial (b) Date thereof 7/28/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director: Sullivan Brothers
2849 N. Euclid

(b) Address _____

19. (a) JUL 26 1940 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____

(c) City or town St. Louis **10**
(If outside city or town limits, write "RURAL")

(d) Street No. 3834 Sullivan Ave.,
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 25
year 1940 hour 1 1/2 minute 45 p. M.

21. I hereby certify that I attended the deceased from Jan 1st, 1940 to July 25, 1940
that I last saw her alive on July 24, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: General arteriosclerosis **8 yr**

Due to Age

Due to _____

Other conditions: Cerebral sclerosis **5 cm**
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Major findings: _____

Of operations _____

Of autopsy _____

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 _____

23. Signature R. [unclear] (M. D. or other) _____

Address 1117 N. Grand Date signed July 25

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Albert Mayfield*

Licensed Embalmer No. *3077*

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