DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26722

SEP 25 1940

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 6618

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution:
H G Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 19 Hrs 42 min (Specify whether years, months or days)

In this community 10 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St Louis 16 22
(If outside city or town limits, write "RURAL")

(d) Street No. 12 a S Channing
(If rural, give location)

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

3. (a) PRINT FULL NAME Jossie Ellett 4 30

3. (b) If veteran, name war -------

3. (c) Social Security No. ----------

4. Sex Female

5. Color or race Col.

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

6. (b) Name of husband or wife Obie Ellett

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Unavailable (Month) Abt. (Day) 1883 (Year)

8. AGE: Years Abt. 57 | Months | Days | If less than one day hr. min.

9. Birthplace St. Clair (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Housework

11. Industry or business None

FATHER
12. Name Tom Coleman
13. Birthplace Unavailable (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Unavailable
15. Birthplace Unavailable (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Clarence Ellett
(b) Address 4520 Aldine Avenue

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-4-1940 (Month) (Day) (Year)
(c) Place: burial or cremation St. Clair, Missouri

18. (a) Signature of funeral director Chas J Gates
(b) Address 4107 Finney Avenue

19. (a) AUG 4 1940 (Date received local registrar) (b) J. E. Broderick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 1 year 1940 hour 1:52 minute A M.

21. I hereby certify that I attended the deceased from July 31, 1940, to August 1, 1940; that I last saw her alive on August 1, 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardiac Hypertrophy	
Pulmonary Edema	5 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy As above	

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

23. Signature J. W. Johnson (M. D. or other)
Address 2601 N. Whittier Date signed 8 1/40

(Licensed Embalmer's Statement on Reverse Side)

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

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

James A. Johnsnn, Registered Apprentice No.

working under my personal supervision.

Signed James A. Johnson

Licensed Embalmer No. 3522

P. O. Address 4107 Finney Ave.

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

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