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7-39
K23159

NOV 25 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

36374

State File No. _____

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 1869

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: 7425 Warwick Dr.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Normandy
(If outside city or town limits, write "RURAL")

(d) Street No. 7425 Warwick Dr.
(If rural, give location)

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

3. (a) PRINT FULL NAME Ella V. Chauncey

3. (b) If veteran, name war No.

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Fred

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

7. Birth date of deceased July 7 1857
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>83</u>	<u>2</u>	<u>25</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name William Sawdey

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

14. Maiden name Martha Wehtworth

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

16. (a) Informant Nina Fette

(b) Address 5244 Cabanne Ave.

17. (a) Burial (b) Date thereof 10-5-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wentzville, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) OCT - 4 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month 10 day 2 year 1940 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from Aug 19 36, 1940 to Oct 21, 1940 that I last saw him alive on Oct 2, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hem. Duration 1 mo.

Due to Arterio-Sclerosis

Due to Ch. Bronchitis

Other conditions add. Fr. of Hip
(Include pregnancy within 3 months of death)

Major findings: Of operations [Signature]

Of autopsy [Signature]

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) [Signature]

(b) Date of occurrence [Signature]

(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? [Signature]

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

23. Signature [Signature] (M. D. or other) [Signature]

Address 810 S. Page & 1/2 block State signed 10-9-40

(Licensed Embalmer's Statement on Reverse Side)

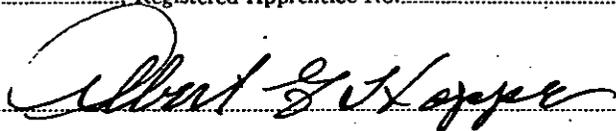
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....



Licensed Embalmer No. 2971.....

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, fact should be so stated above.