

Registration District No. 7911

Primary Registration District No. 1003

Registrar's No.

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: St. Anthony's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days
(Specify whether
In this community Life
years, months or days)

FILED DEC 11 1940

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis / 0
(If outside city or town limits, write "RURAL")
(d) Street No. 4039 Lee Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 2
year 1940 hour 1 minute 30 P. M.

21. I hereby certify that I attended the deceased from July 1 1940
to Nov 2 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Thrombosis of Rt Subclavian artery caused by media-sternal tumor
Duration 4 mo
Due to _____

Other conditions Benign
(Include pregnancy within 3 months of death)
Major findings: Of operations

Of autopsy media sternal tumor thrombosis of Rt Subclavian artery
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) _____ (Means of injury)
23. Signature Dr. W. Walters (M. D. or other)
Address 3608 8th Date signed 10/3/40

3. (a) PRINT FULL NAME Clara S. Ellerbrock

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex F 5. Color of race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife August H. 6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased Dec. 10, 1892
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
47 10 22 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Theo. Miller

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

14. Maiden name Lizzie Gellermann

15. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant R. F. Ellerbrock

(b) Address 4039 Lee Avenue

17. (a) Burial (b) Date thereof 11/5/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director R. M. McLaughlin

(b) Address 2301 Lafayette Ave

19. NOV 5 1940 (b) J. B. Budeak
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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.....

Paul A. Keith

Licensed Embalmer No.....

3612

P. O. Address.....

2317 Lafayette

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.