

No. 2
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17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 12 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

303

Registration District No. **318** Primary Registration District No. **1003** State File No. _____ Registrar's No. **18**

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis,**
(c) Name of hospital or institution: **1600 S.14 Str.**
(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)

3. (a) PRINT FULL NAME **Ella Fone**
3. (b) If veteran, name war. **----** 3. (c) Social Security No. _____
4. Sex **Female** 5. Color or race **Wht.**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Alfred Fone** 6. (c) Age of husband or wife if alive **55** years
7. Birth date of deceased **Oct. 4 1876**
(Month) (Day) (Year)

8. AGE: Years Months **28** If less than one day
67 **3** **29** hr. min.

9. Birthplace **Illinois** (City, town, or county) (State or foreign country)
10. Usual occupation **Housewife**

11. Industry or business **Baer**
12. Name _____
13. Birthplace **Illinois** (City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **Alfred Fone**
(b) Address **1600 S.14 Str.**
17. (a) **Burial** (b) Date thereof **1/3/44**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **New St. Marcus**
18. (a) Signature of funeral director **Wm. E. Maydell**
(b) Address **1926 Allen Ave**
19. (a) **JAN 3 1944** (b) **J. F. Brudiek**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis,**
(If outside city or town limits, write "RURAL")
(d) Street No. **1600 S.14 Str**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Jan.** day **1** year **1944** hour **1** minute **20 A.M.**
21. I hereby certify that I attended the deceased from **Dec 28** 19**43** to **Dec 31** 19**43**
that I last saw her alive on **Dec. 31** 19**43** and that death occurred on the date and hour stated above.

Immediate cause of death **Parotid-Enteritis 2 1/2 days**
Due to _____
Due to **1/20**
Other conditions **Cardiac Asthma 2 yrs.**
(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 _____
23. Signature **Arthur J. Fungel** (M. D. or other) _____
Address **1845 S. 14 St** Date signed **Jan 2-44**

(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 me

Registered Apprentice No. _____

working under my personal supervision.

Signed

A. M. David

Licensed Embalmer No. 3741

P. O. Address 1926 Allen ave

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.