

S. No. 2  
FORM-5-43  
REV. 5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Registration District No. **318** Primary Registration District No. **1003** State File No. **18655** Registrar's No. **5733**

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
5464 Claxton Ave.  
(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 Ellenora E. Domermuth  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife William F. Domermuth 6. (c) Age of husband or wife if alive Deed. years  
7. Birth date of deceased April 9th, 1875  
(Month) (Day) (Year)

8. AGE: Years 70 Months 2 Days 21 If less than one day hr. min.

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

10. Usual occupation Housework

11. Industry or business \_\_\_\_\_

12. Name Louis Licker  
13. Birthplace St. Louis, MO.  
(City, town, or county) (State or foreign country)

14. Maiden name Johanna Hoppe  
15. Birthplace Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant Emma Meyer  
(b) Address 5464 Claxton Ave.

17. (a) Burial (b) Date thereof 7-3-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation St. Peters Cemetery

18. (a) Signature of funeral director Provost Und. Co.  
(b) Address 3710 N. Grand Bl.

19. (a) JUL 2 1945 (b) J. F. Briedeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 000  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5464 Claxton Ave.  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30th, year 1945 hour 5.45 minute A. M.

21. I hereby certify that I attended the deceased from June 30, 1944 to June 30, 1945 that I last saw her alive on June 20, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Arterio Sclerosis Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to Arterio Sclerosis

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 92 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 Henry P. ... (M. D. or other) \_\_\_\_\_  
Address 4916 Grand Date signed \_\_\_\_\_

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 Frank J. Wyland  
Licensed Embalmer No. 2645  
P. O. Address 3634 Gravin 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.**