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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
#50490  
THE STATE BOARD OF HEALTH OF MISSOURI  
FILED DEC 7 1945 STANDARD CERTIFICATE OF DEATH

35219

State File No. \_\_\_\_\_  
Registrar's No. 10229

Registration District No. 318 Primary Registration District No. 1003

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

1. PLACE OF DEATH:  
(a) County St. Louis, Mo.  
(b) City or town (If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff  
(If not in hospital or institution, write street number or location) Memorial  
(d) Length of stay: In hospital or institution 12 days (Specify whether In this community years, months or days)

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") 17  
Street No. 4223 Margaretta Ave 9/0  
(If rural, give location) 0  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country.

3. (a) PRINT FULL NAME Augusta Rose Ellerman  
3. (b) If veteran, name war. 3. (c) Social Security No.  
4. Sex Female / 5. Color or race Wh / 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Wm. G. Ellerman 6. (c) Age of husband or wife if alive 60 years  
7. Birth date of deceased July 3 1895 (Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov. day 25th  
year 1945 hour 10:40 minute A M.  
21. I hereby certify that I attended the deceased from 11/12/45 to 11/25/45  
that I last saw him alive on 11/25/45 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
50 4 22 hr. min.

Immediate cause of death: Brain tumor, frontal lobe malignant  
Due to: \_\_\_\_\_  
Due to: \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death):  
Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_  
Of autopsy: \_\_\_\_\_

9. Birthplace St. Louis - Missouri (City, town, or county) (State or foreign country)  
10. Usual occupation Housewife

11. Industry or business  
12. Name Unknown Bremsteller  
13. Birthplace Germany (City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace (City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant William G. Ellerman  
(b) Address 4223 Margaretta Ave.  
17. (a) Burial (b) Date thereof 11/28/45 (Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Bethlehem Cem.

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?

18. (a) Signature of funeral director Kraeger-Voss, Inc.  
(b) Address 3402 No. Kingshighway  
19. (a) NOV 27 1945 J. Z. Predick (Date of local registration) (Registrar's signature)

While at work? (Specify type of place) (c) Cause of injury  
23. Signature R. L. Stubblefield (M. D. or other) 11/26/45  
Address 1519 Lafayette Date signed 11-26-45

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.

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.**