

LED NOV 29 1945

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **10098**

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: 4943 Buckingham Court /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 62 years (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4943 Buckingham Court  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ELLA D. ELLERMAN

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years (Day) (Year)

7. Birth date of deceased January 12 1883  
(Month) (Day) (Year)

8. AGE: Years 62 Months 10 Days 8 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Secretary-Treasurer

11. Industry or business Litho. & Prtg.

12. Name William Ellermann

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

14. Maiden name Emilie Hohlt

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

16. (a) Informant Mrs. Pauline Ellerman  
(b) Address 611 Dover Place

17. (a) Entombment \_\_\_\_\_ (b) Date thereof Nov. 23, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mt. Hope Mausoleum

18. (a) Signature of funeral director BEIDERWIEDEN F. HOME, INC.  
(b) Address 1936 St. Louis Avenue

19. (a) NOV 29 1945 (b) J. S. Predeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 20  
year 1945 hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from Aug 8  
1934 to Nov 20 1945  
that I last saw him alive on Nov 19 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 3 years

Due to Vascular hypertension 11 yrs

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 5 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature Arnold B. Grant (M. D. or other) MD  
Address 1145 N Taylor Date signed 11/21/45

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

MOTHER FATHER

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

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 *Theo. W. Bairdinger*

Licensed Embalmer No. *506*

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.**