

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

State File No.

Registration District No. **318**

Primary Registration District No. **1005**

Registrar's No. **10648**

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:
Deaconess Hospital
(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)

In this community.....
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Charles**

(c) City or town **Rural**
(If outside city or town limits, write "RURAL")

(d) Street No. **Near New Melle, Mo.**
(If rural, give location)

(e) Citizen of foreign country? **!** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Elizabeth Margaret Ellerman**

MEDICAL CERTIFICATION

3. (b) If veteran, name war **Nil**

3. (c) Social Security No. **None**

20. DATE OF DEATH: Month **Dec.** day **5**
year **1945** hour..... minute..... M.

4. Sex **Female** **5. Color or race** **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Charles Ellerman**

6. (c) Age of husband or wife if alive **81** years

7. Birth date of deceased **January 30 1879**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **12-3-**
1945 to **12-5-** **1945**

that I last saw **her** alive on **12-5-** **1945**
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
66	11	2hr.min.

Immediate cause of death.....
Convulsion

Due to.....
meningitis - "fly" **3 days**

Due to.....
Influenza **6 days**

Other conditions.....
(Include pregnancy within 3 months of death)
None

9. Birthplace **St. Charles Co. Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business.....

12. Name **Christine Henritz**

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

14. Maiden name **Margarett Schmidt**

15. Birthplace **Unknown Germany**
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations.....

Of autopsy **meningitis probably influenza**

16. (a) Informant **Charles Ellerman, Jr.**

(b) Address **Foristell, Missouri**

17. (a) Burial **(b) Date thereof 12-8-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Caplian, Missouri**

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 **Albert H. Hoppe**

(b) Address **4700 Washington Blvd.**

19. (a) DEC 7 1945 **J. F. Brueck**
(Date received by registrar) (Registrar's signature)

While at work?.....
(Specify type of place)

Means of injury.....

23. Signature **W. F. Jensen** **(M. D. or other)**

Address **3115 D. Grand** **Date signed** **12/7/45**

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:.....

Elmo R. Padwell

Licensed Embalmer No. 4077

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.