

3. No. 2
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5-17-39
P1 X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 21 1947
318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. 15037
Registrar's No. 3802

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Luthern Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 weeks
In this community 59Yrs 7 Mons 6 Days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Susan Ellis
3. (b) If veteran, name war no
3. (c) Social Security No. none

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Richard Ellis
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: 8 2 1887
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
59 7 6 hr. _____ min.

9. Birthplace St. Louis Mo. 0
(City, town, or county) (State or foreign county)

10. Usual occupation housework

11. Industry or business _____

MOTHER FATHER { 12. Name James Graves 4
13. Birthplace Unknown IRELAND
(City, town, or county) (State or foreign county)
14. Maiden name Kate Scott 4
15. Birthplace unknown Ireland
(City, town, or county) (State or foreign county)

16. (a) Informant Mr Francis Graves
(b) Address 4204 Warne Ave.

17. (a) Burial (b) Date thereof 4-11-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Wmalla Cemetery

18. (a) Signature of funeral director [Signature]
(b) Address 2228 St. Louis Ave.

19. (a) APR 10 1947 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County oao
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4204 Warne Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 8
year 1947 hour 8 minute 25 a. m.
21. I hereby certify that I attended the deceased from March 1947 to April 8 1947
that I last saw h. alive on April 8 1947
and that death occurred on the date and hour stated above.

Immediate cause of death chronic cardiac disease
myocardial infarction
Due to Plumage with effusion
Due to _____

Other conditions (Include pregnancy within 3 months of death) 95

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) _____ (e) Means of injury _____
Signature [Signature] (M. D. or other) MD
Address 3657 Grand St Date signed 4/10/47

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

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Elmer R. Caldwell

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.