

FILED JUL 6 1948

Primary Registration District No. 3063

Registrar's No. 1326

1. PLACE OF DEATH:  
(a) County St. Louis County  
(b) City or town CLAYTON  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis County Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 DAYS  
(Specify whether years, months or days) 25 YEARS

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO. (b) County St. Louis Co.  
(c) City or town WELLSTON  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6448 MYRTLE  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ELLEN OSTER

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 SEPARATED

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

7. Birth date of deceased MAR. 12 1876  
(Month) (Day) (Year)

8. AGE: 66 Years Months 7 Days 2 22  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace COUNTY MAYO IRELAND  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

12. Name DANIEL MADDEY

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

14. Maiden name CATHERINE KELLY

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

16. (a) Informant HOSPITAL RECORD

(b) Address St. Louis County Hospital

17. (a) \_\_\_\_\_ (b) Date thereof 6/7/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindbergh Blvd.  
(c) 6-4-48 (Date received local registrar) (b) Carl A. Shaw MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 4  
year 1948 hour 8 minute 30 A.M.

21. I hereby certify that I attended the deceased from JUNE 1, 1948, to JUNE 4, 1948;  
that I last saw her alive on JUNE 4, 1948;  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertension  
Cardiac insufficiency

Due to Chronic glomerulonephritis 10 20 yrs

Due to 131

Other conditions Pyometria & Prostatitis  
(Include pregnancy within 3 months of death)

due to Bacterial infection  
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? \_\_\_\_\_

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

23. Signature W. E. Yeigel (M. D.)  
Address 601 Greenwood Blvd Date signed 6/4/48

MOTHER, FATHER

Duration

2 wks

10 20 yrs

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 William Matro

Licensed Embalmer No. 2815

P. O. Address. 4340 Lafayette

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. July

Registration District No. 317

Primary Registration District No. 3063

Registrar's No. 1396

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

3. (a) PRINT FULL NAME Ellen Ester  
3. (b) If veteran, C name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W  
6. (a) Single, widowed, married, divorced div  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased mar 12  
(Month) (Day) (Year)

8. AGE: Years 66 Months 2 Days \_\_\_\_\_ (less than one day)  
hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Ireland  
(City, town, or county) (State or foreign country)

10. Usual occupation Stenographer

MOTHER FATHER

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

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

13. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions: \_\_\_\_\_ (Include pregnancy within 3 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? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

**SUPPLEMENTARY**

S-21539