

FILED JUN 9 1950

THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18549**
4798
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1002		Registrar's No.	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2259	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital				d. STREET ADDRESS (If rural, give location) 1327 Cole St 0			
3. NAME OF DECEASED (Type or Print) a. (First) Ella			b. (Middle) _____			c. (Last) Pulliam	
4. DATE OF DEATH (Month) (Day) (Year) May 27 1950		5. SEX F		6. COLOR OR RACE Col		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	
8. DATE OF BIRTH 4-1-1880		9. AGE (In years last birthday) 70		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) St. Louis Missouri				12. CITIZEN OF WHAT COUNTRY? U.S.A			
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Will Pulliam Dead			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Mary M. Cray 1327 Cole St.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Heart Disease DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH Undet	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? HHX				22. I hereby certify that I attended the deceased from 5-22 , 19 50 , to 5-27 , 19 50 , that I last saw the deceased alive on 5-27 , 1950, and that death occurred at 11 a m., from the causes and on the date stated above.	
23a. SIGNATURE James J. Hedrick (Degree or title) _____		23b. ADDRESS 2601 N Whittier St.		23c. DATE SIGNED 5-29-50			
24a. BURIAL, CREMATION, REMOVAL (Specify) 1		24b. DATE 6-3-50		24c. NAME OF CEMETERY OR CREMATORY Oak Dale Cemetery - St. Louis Co. Mo.		24d. LOCATION (City, town, or county) (State) _____	
DATE REC'D BY LOCAL REG. MAY 31 1950		REGISTRAR'S SIGNATURE J. B. Sasser		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Gus Howe 2950 Dickson St.			

WRITE PLAINLY—USING 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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed

Arthur R. Halliard

Signed.....
Student Embalmer

Licensed Embalmer No. *4221*

P. O. Address *4049 St. Francis*

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.