

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007071

STATE FILE NUMBER

2-1493

FILED MAR 2 1959 Registration District No. _____ Primary Registration District No. _____ Registrar No. 1493

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, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital		d. STREET ADDRESS (If outside, give location) 3009 Mt. Pleasant	
Length of stay in lb 16 weeks		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Minnie (N.M.L.) Ellenberger			4. DATE OF DEATH Month Day Year February 9, 1959		
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5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4, 1870	9. AGE (In years last birthday) 88	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Edwardsville, Illinois	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME August Nast	13b. MOTHER'S MAIDEN NAME Rosalie Rudolph	14. NAME OF HUSBAND OR WIFE Chas. A. Ellenberger (dec.)
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Minnie Hammer, 7516 S. Grand Ave. St. Louis	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPOSTATIC PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 1 wk.
DUE TO (b) FRACTURE OF RT HUMERUS and FRACTURE OF RT. HIP.		4 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) RESIDUAL HEMIPLEGIA FROM OLD CVA		

20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) PT FELL AT HOME ON 10/22/58
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20c. TIME OF INJURY Hour Month, Day, Year 2 p.m. 10/22/58	E 904.0 21
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 156 Home	20f. CITY, TOWN, OR LOCATION 3009 MT. PLEASANT	COUNTY ST LOUIS	STATE MO.
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21. I attended the deceased from Death occurred at 6:20 P.M. 1/6/59 , to 2/9/59 and last saw him alive on 2/8/59

22a. SIGNATURE (Degree or title) Charles Staeck M.D.	22b. ADDRESS 7430 Virginia Ave	22c. DATE SIGNED 2/11/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-12-1959	23c. NAME OF CEMETERY OR CREMATORY St. Pauls Churchyard	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
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24. FUNERAL DIRECTOR Hoffmeister Colonial Mortuary 6464 Chippewa Street, St. Louis, Mo.	25. DATE RECD. BY LOCAL REG. FEB 11 1959	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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, Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Louis C. Hoffman*

Licensed Embalmer No. *3871*

P. O. Address *7814 S. Box*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.