LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

18708

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH
County St Louis — Registration District No. 1123 — File No.
Township Carondalet — Primary Registration District No. 6248 G. — Registered No. 226
City (No. St. Ward)

2. FULL NAME Frederick Ellmo.
(a) Residence. No. South Affton St., Ward. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary Cecelia Ellmo nee Tillman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 8th 1835

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
86.	4	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Chemist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

PARENTS
10. NAME OF FATHER August Ellmo
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Not Know.
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

14. INFORMANT Hugo Ellmo
(Address) R.F.D. #8 Jefferson Barracks Mo

15. FILED July 16, 1921 L. C. Obrock M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 13th 1921

17. I HEREBY CERTIFY, That I attended deceased from July 2, 1920, to July 14, 1921 that I last saw him alive on July 12, 1921, and that death occurred, on the date stated above, at 6 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS: General debility of aged
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Arterial sclerosis
(duration) 5 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? no
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? physical Exam
(Signed) Walter L Kelley, M.D
, 19 (Address) Affton Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Old St Pauls Cemetery — DATE OF BURIAL: July 15 1921

20. UNDERTAKER: John G Koch — ADDRESS: Fenton Mo

N. B.—Every [illegible] should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DE[illegible] terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ... St. ..... Ward)

2. FULL NAME .....

(a) Residence. No..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

N. B.—Every item of information should be carefully suppl
CAUSE OF DEATH in plain terms, so that it may be prop

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED ....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19..... to ....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... mos.
.....
.....
..... mos.
.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY) .....
.....(duration)... .....yrs. .....mos.

18. WHERE WAS DISEASE CONTRACTED .....

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF..... , M.

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?..... n VIOLENT CAUSES, state CCIDENTAL, SUICIDAL, or

(Signed).....

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICID HOMICIDAL. (See reverse side for additional space.)

DATE OF BURIAL
19
ADDRESS

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BUF

20. UNDERTAKER | ADDRESS

STORY.