

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

Do not use this space.

22631

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City..... St. Louis City Infirmary

File No.....
Registered No. 6279
St. Ward)

2. FULL NAME

Ellen Ritter Thomas
(a) Residence. No. 3243 Potis Pl. St. 13 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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 25-1883

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>74</u>		<u>5</u>	<u>12</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Nil
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

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

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Mrs Davis
(Address) 3243 Potis Place

15. FILED 11-8-1927 May 6 Starks
19... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 7 1927

17. I HEREBY CERTIFY That I attended deceased from May 25, 1927, to July 7, 1927 that I last saw him alive on July 7, 1927, and that death occurred, on the date stated above, at 11:15 p.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
General Peritonitis

Ruptured Gastric Ulcer
(duration) 2 yrs. 2 mos. 2 ds.

CONTRIBUTOR (SECONDARY) Chronic Myocarditis
(duration) ? yrs. ? mos. ? ds.

18. WHERE WAS DISEASE CONTRACTED Not known
IF NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH. No DATE OF
WAS THERE AN AUTOPSY. Yes

WHAT TEST CONFIRMED DIAGNOSIS Clinical & Autopsy
(Signed) George H. Garrison M. D.
, 19 (Address) City Infirmary

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Barlyle Illinois DATE OF BURIAL July 8 1927

20. UNDERTAKER E. J. Schmur ADDRESS 3125 Lafayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WITH UNFADING INK—THIS IS A PERMANENT RECORD

