

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

Do not use this space.

38798

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis, Mo.*

Registration District No. *7911*
Primary Registration District No. *1002*
City Hospital # *2*

File No.....
Registered No. *11217*
St. Ward)

2. FULL NAME

Will' Ellis
(a) Residence. No. *3701 Market* St. *18* Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred *36* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>male</i>	4. COLOR OR RACE <i>col</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Separated</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF —		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>unknown</i>		
7. AGE YEARS <i>abt 50</i>	MONTHS —	DAYS —
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <i>Laborer</i> (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)
mo

10. NAME OF FATHER
Dave Ellis

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

12. MAIDEN NAME OF MOTHER
unknown

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

14. INFORMANT (Address)
*A. Gertrude Creach
City Hospital #2*

15. FILED *NOV 18 1929* 19. *Nov 18 1929*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *11/15/1929*

17. I HEREBY CERTIFY, That I attended deceased from *11-13-1929* to *11-15-1929*, 19*29* that I last saw him alive on *11-15-1929* and that death occurred, on the date stated above, at *7 P.M.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic myocarditis
(duration) *7* yrs. *7* mos. *—* ds.

CONTRIBUTORY (SECONDARY)
(duration) *—* yrs. *—* mos. *—* ds.

18. WHERE AND 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?
(Signed) *A. E. Hale*, M. D.
11/16/1929 (Address) *City Hosp #2*

*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
Washington Park Cem DATE OF BURIAL *11-19 1929*

20. UNDERTAKER
Peoples Undert Co. ADDRESS *Franklin*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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