

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

1. PLACE OF DEATH:

(a) County _____

(b) City or town Saint Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Ellen Fitzler 324

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widow

6. (b) Name of husband or wife Theodore Fitzler 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec 25 1886
(Month) (Day) (Year)

8. AGE: Years 52 Months 7 Days 21 If less than one day _____ hr. _____ min.

9. Birthplace Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Louis Shepack

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Mary Stackforth

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Vera Daniels

(b) Address 4541 Chouteau

17. (a) Burial (b) Date thereof Aug 18 1939
(Buried, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cem.

18. (a) Signature of funeral director E. J. Schmur

(b) Address 3125 Lafayette Ave.

19. (a) AUG 18 1939
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town Saint Louis 18
(If outside city or town limits, write "RURAL")

(d) Street No. 4541 Chouteau Ave.
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 15
year 39 hour 10 minute 45 P.M.

21. I hereby certify that I attended the deceased from Aug 14
1939 to Aug 17 1939
that I last saw her alive on Aug 15 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Acute bacterial meningitis Duration 2 da

Due to _____

Due to _____

Other conditions Hypertensive Pneumonia 1 da
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Major findings: unspecified

Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Manner of injury _____

23. Signature R. J. Shaulker (M. D. or other) _____

Address 1714 S Jefferson Ave Date signed 8/17/39

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

jos B Vollmer

Licensed Embalmer No. *4014*

P. O. Address *3125 Lafayette ave*

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; above space should be left blank.