

FILED SEP 25 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27392**
Registrar's No. **7288**

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **EnRoute To City Hospital** **3**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community **Life**
years, months or days)

3. (a) PRINT FULL NAME **NICHOLAS ELLEBRECHT** **4/6**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or **White** 6. (a) Single, widowed, married, **Married**

6. (b) Name of husband or wife **Anna Ellebrecht** 6. (c) Age of husband or wife if alive **69** years

7. Birth date of deceased **Dec 5th 1864**
(Month) (Day) (Year)

8. AGE: 75 Years 8 Months 23 Days If less than one day
hr. min.

9. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Night Watchman**

11. Industry or business _____

12. Name **Herman Ellebrecht** **6**

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

14. Maiden name **Sophie Stord**

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

16. (a) Informant **Anna Ellebrecht**

(b) Address **5235 Delor St.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Aug 31/40**
(Month) (Day) (Year)

(c) Place: burial or cremation **New S.S. Peter & Paul**

18. (a) Signature of funeral director **[Signature]**
(b) Address **2906 Gravois Ave.**

19. (a) **AUG 29 1940** (Date received local registrar) (b) **[Signature]** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **0 Missouri** (b) County _____
(c) City or town **St. Louis** **14**
(If outside city or town limits, write "RURAL")
(d) Street No. **5235 A Delor St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **28**
year **1940** hour **9 05** A.M. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration **3**

Renay Oeluseen

Due to _____

Arthur Scherer

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations **9/4/40**

Of autopsy _____

PHYSICIAN
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? **8/4/40**

(e) Means of injury **5**

23. Signature **[Signature]** (M. D. or other)

Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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.....

Thos. Curtis

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

working under my personal supervision.

Signed.....

Thos Curtis

Licensed Embalmer No.....

1629

P. O. Address.....

2906 Havana

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.