

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **30715**

Registration District No. **79Y 35 1940**

Primary Registration District No. **1003**

Registrar's No. **7992**

1. PLACE OF DEATH:

(a) County **St. Louis**
 (b) City or town **St. Louis**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Lukes
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1 day**
 (Specify whether
 In this community _____
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
 (c) City or town **Maplewood** **NR**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **7548 Rannels**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

8. (a) PRINT FULL NAME **Marjorie C. Ellerbeck**

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

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Robert Ellerbeck** 6. (c) Age of husband or wife if alive **35** years

7. Birth date of deceased **April 1, 1908**
 (Month) (Day) (Year)

8. AGE: Years **32** Months **5** Days **22** If less than one day hr. min.

9. Birthplace **St. Louis, Missouri** 0
 (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife** 0

11. Industry or business 0

MOTHER-FATHER { 12. Name **Henry Christopher**

18. Birthplace **St. Louis, Missouri**

14. Maiden name **Alma Stephenson** (State or foreign country)

15. Birthplace **St. Louis, Missouri** (State or foreign country)

16. (a) Informant **Robert Ellerbeck**
 (b) Address **7548 Rannels**

17. (a) **Cremation** (b) Date thereof **9-26-1940**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Valhalla**

18. (a) Signature of funeral director **Jay B. Smith**

(b) Address **7456 Manchester**

19. (a) **SEP-25-1940** (b) *J. F. [Signature]*

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **23**
 year **1940** hour **10** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **Sept. 21**, 1940, to **Sept. 23**, 1940;
 that I last saw her alive on **Sept. 23**, 1940;
 and that death occurred on the date and hour stated above.

Immediate cause of death: **Septicaemia, haemolytic streptococcus** 3 days

Due to **Acute tonsillitis, non-diphtheritic** 5 days

Due to _____

Other conditions **bronchopneumonia - terminal** 24 hrs.
 (Include pregnancy within 3 months of death)

Major findings: Of operations **107a**

Of autopsy _____

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) Means of injury _____

23. Signature **Wend Becke** (M. D. or other) _____

Address **3720 Washington** Date signed **9/25/40**

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

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 _____

Licensed Embalmer No. 4029

P. O. Address Maplewood

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.