

No. 2
1-4-41
-17-39
X26390

1003

WED AUG 28 1941

791 Primary Registration District No.

Registrar's No. **5724**

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

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis**
(c) Name of hospital or institution
5139 Raymond Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1**
(Specify whether years, months or days)
In this community **1**
years, months or days

3. (a) PRINT FULL NAME **Ella C. Maule**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Edward M. Maule** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Feb. 28 1857**
(Month) (Day) (Year)

8. AGE: Years **84** Months **4** Days **12**
If less than one day hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER
12. Name **Isiah Chapline**
13. Birthplace **Unknown** 9
(City, town, or county) (State or foreign country)
14. Maiden name **Rachael Smith** 9
(City, town, or county) (State or foreign country)
15. Birthplace **Unknown** 9
(City, town, or county) (State or foreign country)

16. (a) Informant **Roy W. Maule**
(b) Address **5139 Raymond Ave.**

17. (a) **Burial** (b) Date thereof **7-12-41**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Bellefontaine Cem.**

18. (a) Signature of funeral director **Drehmann-Harral**
(b) Address **1905 Union Blvd.**

19. (a) **JUL 11 1941** (b) *[Signature]*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **5139 Raymond Ave.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **10**
year **1941** hour **9** minute **50 A.M.**
21. I hereby certify that I attended the deceased from **Feb 10** 19**41** to **July 10** 19**41**
that I last saw her alive on **July 6** 19**41**
and that death occurred on the date and hour stated above.

Immediate cause of death **Deformities of Age**
Duration _____

Due to _____
Due to _____
Other conditions **Transition - Starvation**
(Include pregnancy within 3 months of death) **acidosis**

Major findings: **None**
Of operations _____
Of autopsy **None** 69
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? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature **O. H. Huseman** (M. D. or other) **O. H. Huseman**
Address **4126 S. Shrew Ave.** Date signed **7-10-41**

Box 7140,
1-320*7-8 PM

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 Warren A. Carver

Licensed Embalmer No. 3534

P. O. Address.....

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, fact should be so stated above.