S. No. 2
4-13-40
5-17-39
X23159

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

RTMENT OF COMMERCE
BUREAU OF THE CENSUS

SEP 17 1941

Registration District No.

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No.

State File No. 27042

Registrar's No. 6834

1. PLACE OF DEATH:

(a) County

(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. John's 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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 0 0 0

(c) City or town St. Louis 1 6 17 9
(If outside city or town limits, write "RURAL")

(d) Street No. 3436 Arsenal St.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Wilson W. Elsey Sr.

3. (b) If veteran, name war None

3. (c) Social Security No. 492-01-0705

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Late May Elsey

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Oct. (Month) 23rd (Day) 1874 (Year)

8. AGE: Years	Months	Days	If less than one day
66	9	30	hr. min.

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

10. Usual occupation Steamfitter

11. Industry or business

FATHER
12. Name David Elsey
13. Birthplace (City, town, or county) Vermont (State or foreign country)

MOTHER
14. Maiden name Elizabeth Cinnamon
15. Birthplace (City, town, or county) Canada (State or foreign country)

16. (a) Informant Wilson Elsey Jr.
(b) Address 3436 Arsenal St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-25-41 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Kriegshauser Mortuaries
(b) Address 4228 So. Kingshighway Blvd.

19. (a) AUG 22 1941 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 22nd year 1941 hour 1:45 minute A.M. M.

21. I hereby certify that I attended the deceased from 8-20, 1941, to 8-22-41, 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature E. H. Bowdern (M. D. or other) O
Address 634 N. Grand Date signed 8-22-41

(Licensed Embalmer's Statement on Reverse Side)

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. .....

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

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

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town .....
(If outside city or town limits, write "RURAL")
(d) Street No. .....
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME .....

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

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

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

7. Birth date of deceased ..... (Month) (Day) (Year)

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

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

10. Usual occupation .....
11. Industry or business .....
12. Birthplace ..... (State or foreign country), Registered Apprentice No. .....
14. Maiden name .....
15. Birthplace ..... (City, town, or county) (State or foreign country)
(a) Address .....
17. (a) Place: hospital or cemetery ..... (b) Date: month ..... (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: hospital or cemetery .....
(b) Address .....
19. (a) ..... (Date received for registration) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ..... day ..... year ..... hour ..... minute ..... 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 .....
Due to ....
Due to ....
Due to ....
Other conditions .....
(Specify within 3 months of death)
Major findings: .....
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? .....
(Specify type of place)

23. Signature ..... (M. D. or other)
Address ..... Date signed .....

(Licensed Embalmer's Statement on Reverse Side)

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 EMBALMER / FOREMAN working under my personal supervision.

Signed Reinhold B. Schroeder

Licensed Embalmer No. 3395

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.

PHYSICIAN — Underline the cause to which death should be charged statistically.

No. 2
3-13-40
1939

Edw. Bowdern

34 Reinhold B. Schroeder

ASK FUNERAL DIRECTOR FOR PRIVATE FUNERAL RECORD — USE OTHERWISE BLACK INK

No. 2B
M—8-21-41
M29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27042

Registration District No. 791 Primary Registration District No. Registrar's No. 6834

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Wilson W Elsey Sr

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

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased (Month) (Day) (Year)

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

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 10-2-41 (Date received local registrar) (b) Jos. F. Baedeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 25
year 1941 hour minute M.
21. I hereby certify that I attended the deceased from
19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
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)
(b) 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 (M. D. or other)
Address Date signed