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DEPARTMENT OF COMMERCE
BUREAU OF CENSUS
NOV 21 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35806

Registration District No. 756

Primary Registration District No. 4454

Registrar's No. 4

1. PLACE OF DEATH:

(a) County St. Charles
(b) City or town Portage, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Rural Route # 3 / Box 21
(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 Missouri (b) County St. Charles
(c) City or town Rural Route # 30
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Catherine Barbara Ell

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

4. L. Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife Joseph 6. (c) Age of husband or wife if 52 years
Aloysius Ell alive 52 years
7. Birth date of deceased December 17 1886
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
54 9 16 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Anton Ocho

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

14. Maiden name Barbara Prosch

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

16. (a) Informant Joseph Aloysius Ell

(b) Address R.R. # 3 - Black Walnut, Mo.

17. (a) Burial (b) Date thereof Oct. 7 - 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Francis Cem., Portage, Mo.

18. (a) Signature of funeral director H.C. Dallmeyer & Sons
(b) Address 800 N. Second, St. Charles, Mo.

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 3
year 1941 hour 7 minute 30 P. M.

21. I hereby certify that I attended the deceased from Feb. 10
1940, to Oct 7, 1941.
that I last saw him alive on Oct 6 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis
Due to General Arterio Sclerosis

Due to _____

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

Major findings: Of operations _____
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 C.A. Barnard (M.D. or other) _____

Address Portage, Mo. Date signed Oct 10

Duration 1.000
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

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0

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..... *John E Dellmeyer*.....
Licensed Embalmer No..... *2951*.....
P. O. Address..... *St Charles Mo*.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35-906**

Registration District No. **756**

Primary Registration District No. **4454**

Registrar's No. **4**

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

1. PLACE OF DEATH:

(a) County St Charles

(b) City or town Carthage
(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)

3. (a) PRINT FULL NAME Catherine Barbara Ell

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..... M

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

7. Birth date of deceased Dec 17 1941
(Month) (Day) (Year)

8. AGE: Years 54 Months 9 Days 1 (If less than one day min.)

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) Oct 5 1941 (b) C. A. Barnard
(Date received local registrar) (Registrar's signature)

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec year 1941 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 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

PHYSICIAN

Underline the cause to which death should be charged statistically.

Due to.....

Due to.....

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

Major findings:
Of operations.....

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)

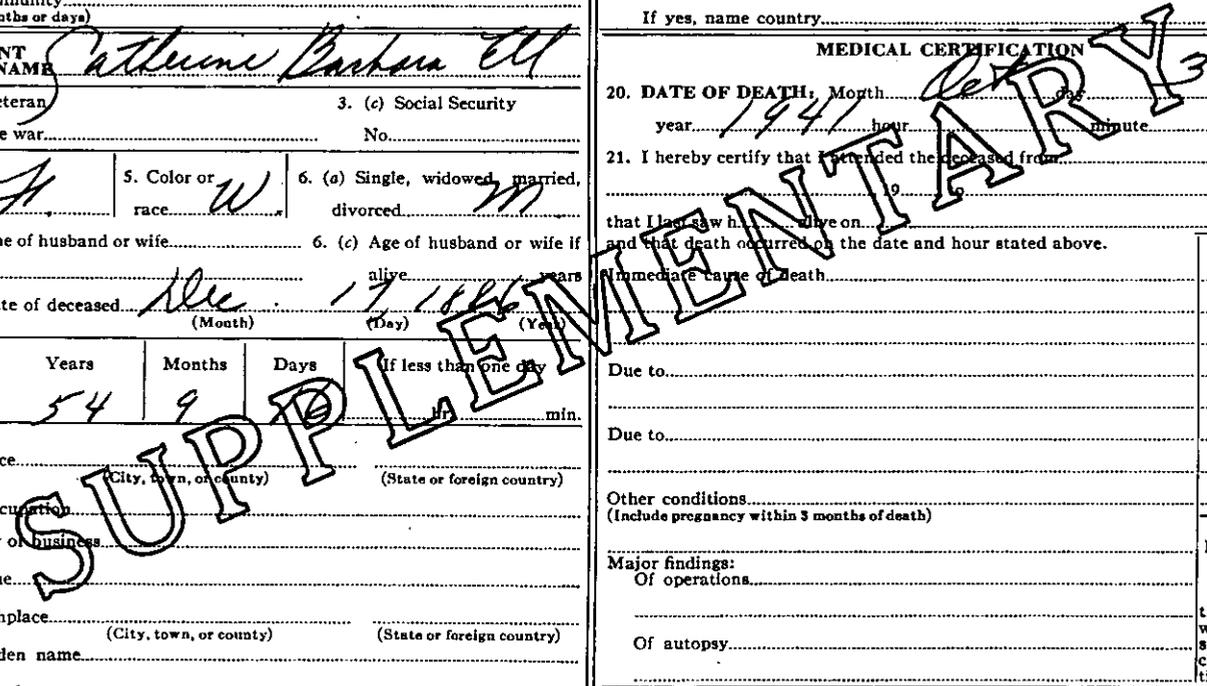
(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work?..... (Specify type of place)

(e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....



S-35906