

No. 2  
-8-43  
-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAY 20 1944

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
1003

16311  
State File No. 4343  
Registrar's No.

Registration District No. 318 Primary Registration District No.

1. PLACE OF DEATH:  
(a) County St. Louis, Mo.  
(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:  
BARNES HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 days (Specify whether  
In this community... years, months or days)

3. (a) PRINT FULL NAME Sam Robert Ellis  
3. (b) If veteran, name war.....  
3. (c) Social Security No.....

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Aramanta Ellis  
6. (c) Age of husband or wife if alive 46 years  
7. Birth date of deceased Dec 18 1890  
(Month) (Day) (Year)

8. AGE: Years 53 Months 8 Days 21  
If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER  
12. Name Robert Ellis  
13. Birthplace Fairfield, Illinois  
(City, town, or county) (State or foreign country)  
14. Maiden name Nancy Vernon  
15. Birthplace Fairfield, Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Geneva Ellia  
(b) Address Rinard, Ill.

17. (a) Removal (b) Date thereof 5-10-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Johnsonville, Ill.

18. (a) Signature of funeral director Albert H. Hoppe Inc.  
(b) Address 4700 Washington Blvd.

19. (a) MAY 10 1944 (b) J. F. Beebeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 999  
(a) State Illinois (b) County Wayne  
(c) City or town Rinard  
(If outside city or town limits, write "RURAL") D.V.R.  
(d) Street No..... (If rural, give location)  
(e) Citizen of foreign country? (Yes or No) 2  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9  
year 1944 hour 6:30 minute P M.  
21. I hereby certify that I attended the deceased from May 5, 1944 to May 9, 1944.  
that I last saw him alive on May 9, 1944.  
and that death occurred on the date and hour stated above.  
Immediate cause of death Asotemia

Due to Chronic Myelogenous Leukemia

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy as above

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 John W. Eisenhart (M. D. or other) MD

Address BARNES HOSPITAL Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

844

**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

*Albert G. Koffe*

Licensed Embalmer No.

2971

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.**