No. 2
8-43
17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 12 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11039

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3930

1. PLACE OF DEATH:

(a) County: ST LOUIS

(b) City or town: (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2734 Gamble St. (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: 666

(a) State: Missouri (b) County: 17

(c) City or town: St Louis (If outside city or town limits, write "RURAL")

(d) Street No.: 2734 Gamble St 21 (If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: ELLA BROCK

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: Female

5. Color or race: Col, 3

6. (a) Single, widowed, married, divorced: 2

6. (b) Name of husband or wife

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

7. Birth date of deceased: Oct. (Month) -2 (Day) 1903 (Year)

8. AGE: Years 41 Months 6 Days 29 If less than one day hr. min.

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

10. Usual occupation: Domestic

11. Industry or business

FATHER 12. Name: William E Byars

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

MOTHER 14. Maiden name: Joe Anna Jones

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

16. (a) Informant: Virginia Alexander

(b) Address: 2734 Gamble St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5-7-45 (Month) (Day) (Year)

(c) Place: burial or cremation: Greenwood cem

18. (a) Signature of funeral director: Ellis Fun, Home

(b) Address: 2820 Stoddard St

19. (a) MAY 3 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 1st year 1945 hour 1 minute P. M.

21. I hereby certify that I attended the deceased from 4-26, 1945, to 5-1, 1945, that I last saw her alive on 4-30-45, 19..; and that death occurred on the date and hour stated above.

Immediate cause of death: Myocarditis, Chronic

Due to: unknown

Due to:

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

Major findings: Of operations:

Of autopsy: no

Duration

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): no

(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: L. Filder (M. D. or other)

Address: 2601 Dickson Date signed: 5-1-45

(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~~ .....

....., Registered Apprentice No. .....,

working under my personal supervision.

Signed Fritton E Culkin

Licensed Embalmer No. 4198

P. O. Address 1215 James St St Louis 13

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.

G. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. mar

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3938

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

4. Sex F
5. Color or race B
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Oct 2, 1903 (Month) (Day) (Year)
8. AGE: Years 41 Months 6 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Ark (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) MAY 18 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May year 1945 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.

Immediate cause of death	Duration
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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

11039