S. No. 2
—9-4-41
5-17-39
PI X29484

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. 25600

FILED SEP 3 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7748

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: LUTHERAN 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 3 days 7 hrs. 46 min years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 006

(c) City or town ST. LOUIS (If outside city or town limits, write "RURAL") 17

(d) Street No. 4941 DEVONSHIRE (If rural, give location) 9/4

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

If yes, name country

3. (a) PRINT FULL NAME JOAN MARIE EHLEN

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex F 1

5. Color or race W

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 8 - 30 - 45 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
—	—	3	7 hr. 46 min.

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

10. Usual occupation Newborn

11. Industry or business

FATHER
12. Name WALTER J. EHLEN
13. Birthplace ST. LOUIS (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name LILLIAN McLEOD
15. Birthplace ST. LOUIS (City, town, or county) Mo (State or foreign country)

16. (a) Informant V. DUECKER RN

(b) Address LUTHERAN HOSPITAL

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9 4 1945 (Month) (Day) (Year)

(c) Place: burial or cremation NEW S.S. PETER & PAUL

18. (a) Signature of funeral director KRIEGSHAUSER UND. CO

(b) Address 4228 SO. KINGSHIGHWAY

19. (a) SEP 4 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 2 year 1945 hour 8 minute 45 P M.

21. I hereby certify that I attended the deceased from August 30, 1945 to Sept 2, 1945 that I last saw her alive on Sept 2, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Starvation

Due to Could not swallow

Due to Monstra per fabricam wrongly formed + displaced brain

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 157 M

Of autopsy

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)

(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 Otto C. Hauser (M. D. or other) MD

Address 3157 Park Av Date signed 9/3/45

(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: Edward L. Mc Dermott

Licensed Embalmer No. 3024

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.