

STANDARD CERTIFICATE OF DEATH

FILED OCT 12 1945

Registration District No. 318

Primary Registration District No. 1003

State File No. 29210  
8636  
Registrar's No.

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:  
Enroute City Hospital 2  
(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 \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1125 S. 10th. St.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 2  
year 1945 hour 9 minute 22 A.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.

3. (a) PRINT FULL NAME Ella Mc Connell

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

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

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

7. Birth date of deceased About 1860  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
About 85 hr. min.

9. Birthplace Grundy City - Illinois  
(City, town, or county); (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Thomas J. Clark

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

14. Maiden name Elizabeth Unknown

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

16. (a) Informant L. Mike Fish

(b) Address Hoopeston, Ill.

17. (a) Removal (b) Date thereof 10-5-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

19. (a) Oct 8th 1945 (b) J. F. Bredeck  
(Data received local registrar) (Registrar's signature)

Immediate cause of death Sudden death - Hemorrhage right side when she was struck by street car manually controlled by Ralph Williams conductor at the intersection of 11th & Chouteau Ave around 7:30 P.M. Oct. 1, 1945

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) Accident

(b) Date of occurrence Oct 1 1945

(c) Where injury occurred? St Louis  
(City or town) (County) (State)

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

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury car

23. Signature John E. Jaylor (M. D. or other)

Address By Car Date signed 10/6/45

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

MOTHER FATHER

9898

9898

**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..... *Chris R. Sedwell* .....

Licensed Embalmer No. *4077* .....

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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. *act*

Registration District No. *318*

Primary Registration District No. *1003*

Registrar's No. *8634*

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)

3. (a) PRINT FULL NAME *Elle McConnell*  
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex *F* 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 *all 1860*  
(Month) (Day) (Year)

8. AGE: Years *all 85* Months Days 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.....  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

(b) Address.....

19. (a) *10-6-1945* (b) *J. F. Bredek*  
(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 *Oct* Day.....  
year *1945* hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....  
that I or saw him/her 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.....

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

SUPPLEMENTARY

1945  
S-29210