

S. No. 2
M-5-43
7-5-17-39
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38989

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED DEC 28 1945
Registration District No. 518

Primary Registration District No. 1003

Registrar's No. 10879

1. PLACE OF DEATH:

(a) County ST. LOUIS MO.
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
712 Rear Carr St /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 10 YRS
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Way
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 712 Rear Carr St / 9
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME ELLA BUTLER

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

4. Sex Female 5. Color or race Negro 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 unknown
(Month) (Day) (Year)

8. AGE: Years abt 68 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation Domestic

11. Industry or business _____

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant John Love

(b) Address 712 Rear Carr St

17. (a) Burial (b) Date thereof 12-15-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director Greenwood
(b) Address 3644 Finney Ave
19. (a) DEC 14 1945 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 5
year 1945 hour 1 minute 30 P. M.

21. I hereby certify that I attended the deceased from 11-17 1945 to Dec 5 1945
that I last saw her alive on Dec 5 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Apoplexy
Due to Arteriosclerosis

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

Major findings: _____
Of operations _____
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? _____

While at work? _____ (Specify type of place)
(e) Means of injury D

23. Signature J.D. Thurman (M. D. or other) _____
Address 30479 Canton Date signed 12-12-45

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

MOTHER FATHER

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 *Louis V. Atkins*

Licensed Embalmer No. *2842*

P. O. Address *3644 Finney*

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.