

#6507
 DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **11085**

Registration District No. **210**

Primary Registration District No. **1005**

Registrar's No. **2239**

1. PLACE OF DEATH:

(a) County **St. Louis, Missouri**
 (b) City or town **St. Louis, Missouri**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis City Hospital - Max C. Starkloff
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
 In this community.....
 years, months or days) (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **St. Louis**
 (c) City or town **St. Louis**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **2003 Cass ave**
Memorial (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME

NED ELLIS

3. (b) If veteran, name war.....

3. (c) Social Security No. **190-12-2481**

4. Sex **Male** 5. Color or race **White**
 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 **May 12, 1870**
 (Month) (Day) (Year)

8. AGE: Years **75** Months **9** Days **23** If less than one day hr. min.

9. Birthplace **Harrison Mo.**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Unemployed**

11. Industry or business.....

MOTHER FATHER { 12. Name **James F. Ellis**
 13. Birthplace **Lynn Ind**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Ruth Ann Ellis**
 15. Birthplace **Arba Ind**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Ed Posik**
 (b) Address **2003 Cass ave**
 17. (a) **Burial** (b) Date thereof **3/8/46**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **St Peters Cemetery**

18. (a) Signature of funeral director **Central Und**
 (b) Address **1841 Cass ave**
 19. (a) **MAR 7 1946** (b) **J. D. Bredees**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **5th**
 year **1946** hour **3:10** minute **A** M.
 21. I hereby certify that I attended the deceased from **2/18/46**
 to **3/5/46**, 19... to **3/5/46**, 19...
 that I last saw him alive on **3/5/46**
 and that death occurred on the date and hour stated above.

Immediate cause of death.....
Anemia
 Due to **Nephrosclerosis**
 Due to **Arterio sclerosis**
Cardiovascular disease
 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?
 While at work?..... (Specify type of place) (e) Means of injury.....
 23. Signature **K. D. Gregory** 1515 Lafayette St
 Address Date signed **3/14/46**

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 John Agostino
Licensed Embalmer No... 3398
P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April
Registrar's No. 22391

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St Louis
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME

Red Ellis

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

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

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

7. Birth date of deceased May 12 1912
(Month) (Day) (Year)

8. AGE: Years 25 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) J. F. Breese
(Date received local registrar)

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 May year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____.

What I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

Duration _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

MAR 25 1946

11085