S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 6 1947

Registration District No. 317

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 7281

Primary Registration District No. 3069

Registrar's No. 429

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: St. Mary's Hospital 0
(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 Illinois (b) County Clinton 999

(c) City or town New Baden 11
(If outside city or town limits, write "RURAL")

(d) Street No. ____ 0
(If rural, give location)

(e) Citizen of foreign country? ____ (Yes or No) 2

If yes, name country ____

3. (a) PRINT FULL NAME Mathilda Ullrich

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 Widow 2

6. (b) Name of husband or wife John Ullrich

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

7. Birth date of deceased May (Month) 7 (Day) 1883 (Year)

8. AGE: Years 63 Months 9 Days 17 If less than one day ____ hr. ____ min.

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

10. Usual occupation Housewife

11. Industry or business ____

FATHER
12. Name George Hammann
13. Birthplace ____ (City, town, or county) Germany 4 (State or foreign country)

MOTHER
14. Maiden name Philomena Weil
15. Birthplace ____ (City, town, or county) Illinois (State or foreign country)

16. (a) Informant Harvey Ullrich
(b) Address New Baden, Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-25-47 (Month) (Day) (Year)
(c) Place: burial or cremation New Baden, Ill.

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

19. (a) 2-22-47 (Date received local registrar) (b) Ruth I. Allen, M.D. (Registrar's signature) BC

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 24 year 1947 hour 11 minute 35 A M.

21. I hereby certify that I attended the deceased from January 21st, 1947, to February 24, 1947; that I last saw her alive on February 24, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Neurogenic Sarcoma	
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 0

23. Signature [signature] (M.D. or other)

Address Sister Dedg. [illegible] Date signed 2/25/47

(Licensed Embalmer's Statement on Reverse Side)

JAN 7 1948
DEC 29 1947

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 Ernest W. Spillard

Licensed Embalmer No. 4080

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.