B. No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 26 1947

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29918

Registration District No. 317

Primary Registration District No. 4467

Registrar's No. 1656

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: Valley Park
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Mott Nursing Home.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)

In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: 000

(c) City or town: St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No.: 3800 Laclede Ave. 9
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No) 1

If yes, name country .....

3. (a) PRINT FULL NAME: Ella Kahlor

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: Married

6. (b) Name of husband or wife: Loren Kahlor

6. (c) Age of husband or wife if alive: 47 years

7. Birth date of deceased: March (Month) 19 (Day) 1902 (Year)

8. AGE:

Years	Months	Days	If less than one day
45	4	13	..... hr. ..... min.

9. Birthplace: Radliffe (City, town, or county) Mississippi (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business .....

MOTHER FATHER

12. Name: Unknown McClure

13. Birthplace: Unknown 9 (City, town, or country) (State or foreign country)

14. Maiden name: Unknown

15. Birthplace: Unknown 9 (City, town, or country) (State or foreign country) 1

16. (a) Informant: Loren Kahlor

(b) Address: 3800 Laclede Ave.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 8-5-47 (Month) (Day) (Year)

(c) Place: burial or cremation: Radliffe, Miss.

18. (a) Signature of funeral director: Albert H. Hoppe

(b) Address: 4700 Washington Blvd.

19. (a) 8-7-47 (Date received local registrar) (b) Bertha J. Sharp MD (Registrar's signature) MD

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 2 year 1947 hour 8 45 minute A M.

21. I hereby certify that I attended the deceased from May 1 1947 to Aug 2 1947 that I last saw her alive on Aug 1 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of the Uterus Invas.	14 Mo
Due to: generalized Metastasis	
Due to: 520	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause of 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) 8

While at work? ..... (e) Means of injury .....

23. Signature: O. Osenbaugh (M. D. or other) MD

Address: Webster Groves Date signed 7/5/49 Mo

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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

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 S Dennehy

Licensed Embalmer No. 4194

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.