

No. 2
-1/47
5:17-39

FILED OCT 20 1947
Registration District No. 3063

Primary Registration District No. 3063

Registrar's No. 9185

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

1. PLACE OF DEATH:

(a) County ST. LOUIS COUNTY

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

(c) Name of hospital or institution ST. LOUIS COUNTY HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 DAYS
(Specify whether years, months or days)

In this community 64 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County ST. LOUIS CO. 96

(c) City or town BRENTWOOD
(If outside city or town limits, write "RURAL")

(d) Street No. 2641 MELVIN
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME ELLA PORTER

3. (b) If veteran, name war _____

3. (c) Social Security No. 492-12-9772

4. Sex FEMALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife JOHN

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

7. Birth date of deceased Feb 26 1883
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT. day 13
year 1947 hour 5 minute 45 A.M.

21. I hereby certify that I attended the deceased from OCT.
11, 1947, to OCT. 13, 1947.

that I last saw her alive on OCT. 13, 1947; and that death occurred on the date and hour stated above.

Duration _____

8. AGE: Years Months Days If less than one day

64 7 27 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Henry Diehl

13. Birthplace St. Louis Mo
(town, or county) (State or foreign country)

14. Maiden name Rose Halberger

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

Immediate cause of death Concussion hemorrhage in brain
Arachnoidal hemorrhage

Due to Trauma

Due to 1700

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

Major findings: Of operations _____

Of autopsy As above

PHYSICIAN _____

Underline the cause of which death should be charged statistically.

16. (a) Informant MELITA BURNHAM

(b) Address 2641 MELVIN AVE

17. (a) Burial (b) Date thereof Oct. 16 - 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial National Cem. Jeff. Barracks

18. (a) Signature of funeral director Louis H. Bopp

(b) Address 128 Kirkwood Ave

19. (a) 10-17-47 (b) George H. Shapton
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ACCIDENT, 26

(b) Date of occurrence OCT. 11, 1947

(c) Where did injury occur? MAPLEWOOD ST. LOUIS CO., MO
(City or town) (County) (State)

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

(Specify type of place) STUCK BY

(e) Means of injury AUTO

23. Signature Russell L. Herdner (M. D. or other) _____

Address 601 BRENTWOOD BLVD Date signed 10/13/47

MAY 13 1948

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.....

Felix Durand

Licensed Embalmer No.....*3034*

P. O. Address *Kirkwood (22) Mo*

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.

Registration District No. 317

Primary Registration District No. 3063

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Clayton
(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 Ella Patten

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 and

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

7. Birth date of deceased Feb 26
(Month) (Day) (Year)

8. AGE: Years 64 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

MOTHER FATHER

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) _____ (b) _____
(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 February year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that 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) (c) Means of injury _____

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

S-36483

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