

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....
(b) City or town ST. LOUIS MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution PERMINS DELodge Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay 2 DAYS In hospital or institution.
(Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County DOO
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 2727 A EADS AVE
27 (If rural, give location)
(e) 27 Citizen of foreign country? (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME ANN MORRIS ILLI

3. (b) If veteran; name war.....
3. (c) Social Security No. 494 26.3046

4. FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife FRED ILLI
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased JAN 10, 1898
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
50 6 19 1 hr. 0 min.

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

10. Usual occupation Housewife

11. Industry or business.....

12. Name JOHN HORAN

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

14. Maiden name ELLEN RAFFORTY

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

16. (a) Informant MARY HORAN

(b) Address 2727 EADS AVE

17. (a) BURIAL (b) Date thereof AUG 2-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation NATIONAL CEMETARY

18. (a) Signature of funeral director Chadwick & Son

(b) Address 2906 BAYVIEW AVE

19. (a) JUL 30 1948 (b) J. F. BULLOCK
(Date received) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 29
year 1948 hour 7:30 minute 0 M.

21. I hereby certify that I attended the deceased from 27 July
..... 1948, to 29 July 1948
that I last saw her alive on 29 July 1948
and that death occurred on the date and hour stated above.

Immediate cause of death
(2) Intestinal obstruction
(Small Bowel - acute) 7 days

(3) Internal Hernia -
(Concomitant)

Due to (1) Cerebral anoxia 6 hrs
Other conditions due to cerebral anoxia to Koravain anoxia

Major findings: Intestinal obstruction
Of operations Small bowel

Of autopsy None

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.....

23. Signature: Edward J. Jordan M.D. (M. D. or other)

Address 1504 South Grand Date signed 29 July 48

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.....

Licensed Embalmer No. *4347*

P. O. Address *2906 Travis*

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. *318*

Primary Registration District No. *1003*

Registrar's No. *6710*

1. PLACE OF DEATH:

(a) County.....
 (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.....
years, months or days)

3. (a) PRINT FULL NAME *Ann M Elli*

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 *wid*

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

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

8. AGE: Years *50* Months *6* Days *10* (Less than one day)
hr. min.

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

10. Usual occupation *housewife*

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.....
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) *AUG 14 1948* (b) *J. F. Bredeck*
(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..... year *1948* 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.....

Duration

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.....

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

Address..... Date signed.....

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

SUPPLEMENTARY

S-24399