

MISSOURI DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 114
Primary Registration District No. 5432

1. PLACE OF DEATH:
(a) County FRANKLIN Meramec Twp
(b) City or town STANTON, MO
(c) Name of hospital or institution: MILLER HOME 4
(d) Length of stay: In hospital or institution 6 MO.
In this community 6 mos.

3. (a) PRINT FULL NAME ELLA HAYES
3. (b) If veteran, name war WW
3. (c) Social Security No. WW

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive 1866 years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 82 Months Days If less than one day hr. min.

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

10. Usual occupation Me

11. Industry or business
12. Name John Hayes
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Dorothy LONG
(b) Address 3964 WEST MINISTER ST. LOUIS MO.

17. (a) REMOVAL (b) Date thereof DEC 19 48 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cem

18. (a) Signature of funeral director G. Sullivan
(b) Address Sullivan, Mo.

19. (a) 12-19-48 (b) G. Sullivan (Registrar's signature) 99
(Date received local registrar) (Date)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County St. Louis
(c) City or town ST. LOUIS, MO.
(d) Street No.
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 19 year 1948 hour 7 minute AM

21. I hereby certify that I attended the deceased from Dec 14 48 to Dec 16 48
that I last saw her alive on Dec 16 48
and that death occurred on the date and hour stated above.

Immediate cause of death: thromboembolism Duration 18 mos

Due to: Malnutrition Duration 14 yr

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

Major findings: Of operations: 20 lb
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?
(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: G. Sullivan (M.D. or other) Address: Sullivan, Mo. Date signed: 12/19/48

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

MOTHER FATHER

RECEIVED
District Health Officer No. 9
District File Number
Date Filed JAN 6 1949

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 Ronald J. Calumke

Licensed Embalmer No. 13917

P. O. Address Theris 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. 114 Primary Registration District No. 0432

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

1. PLACE OF DEATH:
 (a) County Franklin
 (b) City or town Stanton
 (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 Hayes
 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 S
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 82 Months _____ Days _____ If less than one day, hr. min.
 9. Birthplace (City, town, or county) (State or foreign country) Mich

10. Usual occupation _____
 11. Industry or business _____
 MOTHER { 12. Name _____
 FATHER { 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
 (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____
 19. (a) 12-19-48 (b) Ed Prator
 (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 Jan Year 1948 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her 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 _____
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 _____ (M. D. or other) _____
 Address _____ Date signed _____

SUPPLEMENTARY 9

S-39789