

FILED FEB 8 1949

Registration District No.

318

Primary Registration District No.

Registrar's No.

1181

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Missouri Baptist Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 weeks (Specify whether  
in this community 5 weeks years, months or days)

3. (a) PRINT FULL NAME Jennie T. Ely

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex F 5. Color or race W  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Robert W Ely 6. (c) Age of husband or wife if alive            years  
7. Birth date of deceased September 23 1855  
(Month) (Day) (Year)

8. AGE: Years 93 Months 2 Days 4 If less than one day hr. min.

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

10. Usual occupation Housekeeper

11. Industry or business Home

MOTHER FATHER { 12. Name Robert Shields 9  
13. Birthplace Unknown (City, town, or county) (State or foreign country)  
14. Maiden name Isabel Hawks  
15. Birthplace Pa (City, town, or county) (State or foreign country)

16. (a) Informant Helen Ely  
(b) Address 1504 Watson

17. (a) Burial (b) Date thereof Nov 30 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director             
(b) FEB 7 1949 326 North 6th St

19. (a) J. B. Lacater (b) J. B. Lacater  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Charles 92  
(c) City or town St Charles 7  
(If outside city or town limits, write "RURAL") 3  
(d) Street No. 1504 Watson St (If rural, give location)  
N.R.  
(e) Citizen of foreign country? No (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 27  
year 1948 hour 10 minute 15 P.M.

21. I hereby certify that I attended the deceased from 10-18 1948 to 11-27 1948  
that I last saw h. u alive on 11-27 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis; Chronic Duration  
Fractured shaft R. Femur  
Fractured neck femur 18/18

Due to continued confinement  
in hospital following fr. neck of  
right femur  
Secidely 20

Due to            20

Other conditions (Include pregnancy within 3 months of death)            20

Major findings: fr neck femur  
Of operations fr shaft femur PHYSICIAN

Of autopsy            Underline the cause to which death should be attributed statistically.

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

(c) 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 J. B. Lacater (M. D. or other)           

Address 845 Missouri South Blvd Date signed

FEB 8 1949

MAR 2 1949

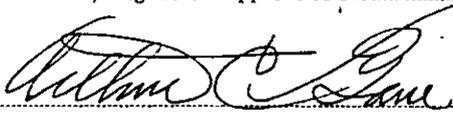
**STATEMENT BY LICENSED EMBALMER**

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.....



Licensed Embalmer No. 3155

P. O. Address St Charles Mo

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

If this body is not embalmed, fact should be so stated above.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. F-11

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1181

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis</u>		b. COUNTY	
c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)	
a. (First) <u>Jessie</u>	b. (Middle) <u>J</u>	c. (Last) <u>ely</u>	<u>11-2-1948</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>9-23-55-</u>	9. AGE (In years last birthday) <u>92</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	
			12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	13c. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		DUE TO (b)		
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) <u>10/8</u>		
2. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.)		<u>89030</u> <u>920</u>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St Charles, Mo.</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Oct 17 1948</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Fall from chair</u>
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22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <u>J.P. Hatcher</u>	MAR 1 1949	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS

SUPPLEMENTARY

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

300  
48

5-42659

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