

FILED APR 4 1950

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11437**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **6076** Registrar's No. **829**

1. PLACE OF DEATH a. COUNTY St. Louis County		2. USUAL RESIDENCE (Where deceased lived. If location: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) Normandy	c. LENGTH OF STAY (In this place) 3 da	c. CITY (If outside corporate limits, write RURAL and give township) Union 0360	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5313 Clear Drive		d. STREET ADDRESS (If rural, give location) Howe Ave. 1	

3. NAME OF DECEASED (Type or Print)	a. (First) ELLA	b. (Middle) B.	c. (Last) MINTELS	4. DATE OF DEATH (Month) (Day) (Year) 3 30 1950
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct. 11, 1883	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months 5 Days 19	IF UNDER 4 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Union Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Edmund Hallmann	13b. MOTHER'S MAIDEN NAME Clara Schuber	14. NAME OF HUSBAND OR WIFE Ethel Edmund
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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 Ms. Lucine Dabel	ADDRESS Normandy Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis		1 day
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Chronic Myocarditis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 420.1			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from **3-24, 1947**, to **3-30, 1950**, that I last saw the deceased alive on **3-30, 1950**, and that death occurred at **7:30** m., from the causes and on the date stated above.

23a. SIGNATURE W. B. Moore	(Degree or title) MD	23b. ADDRESS 7301 Natural Bridge 21 Mo.	23c. DATE SIGNED 3-30-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-2-1950	24c. NAME OF CEMETERY OR CREMATORY Green Cemetery	24d. LOCATION (City, town, or county) (State) Union Mo.
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DATE REC'D BY LOCAL REG. 3-31-50	REGISTRAR'S SIGNATURE Herbert R. Domb	25. FUNERAL DIRECTOR'S SIGNATURE W. B. Moore	ADDRESS Union Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1001

JAN 19 1951

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

M. W. Wilberich

Licensed Embalmer No. 4511

P. O. Address Washington, 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.