

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **28166**

FILED AUG 29 1950

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7067**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>15<sup>th</sup> TOWN St. Louis</b>	
c. LENGTH OF STAY (in this place)		2159	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>3449 Taft</b>		d. STREET ADDRESS (If rural, give location) <b>3449 Taft</b>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) <b>Mollie</b>	b. (Middle) <b>D.</b>	c. (Last) <b>Ellis</b>	Aug. 17		1950
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Dec. 7 1870</b>	9. AGE (In years last birthday) <b>79</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Grand View Ind.</b>	
12. CITIZEN OF WHAT COUNTRY?					

13a. FATHER'S NAME <b>James Hagan</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Lamar</b>		14. NAME OF HUSBAND OR WIFE <b>George (Deceased)</b>	
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 <b>Sina Ellis 3449 Taft</b>	

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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Hypertensive heart disease</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>arteriosclerosis</b> DUE TO (c) <b>Bronchial asthma</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b> <b>5 yrs.</b> <b>10 yrs.</b>	
---	--	---	--	--	--

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>443X</b>	

22. I hereby certify that I attended the deceased from **Jan. 19 40**, to **August 17, 1950**, that I last saw the deceased alive on **August 17, 1950**, and that death occurred at **2P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>George A. O'Sullivan, M.D.</b>		23b. ADDRESS <b>421 N. Schurmer</b>		23c. DATE SIGNED <b>8-18-50</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>8-21-50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Trinity Lutheran Cem.</b>	
24d. LOCATION (City, town, or county) (State) <b>St. Louis County</b>					

DATE REC'D BY LOCAL REG. <b>AUG 2, 1950</b>		REGISTRAR'S SIGNATURE <b>J. B. Sauter</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Wm. Schumacher 3013 Meramec St.</b>	
--	--	--	--	--	--

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

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 \_\_\_\_\_

working under my personal supervision.

Signed.....  
Student Embalmer

Signed *Gustav W. Dutschke*  
Student Embalmer No.....

Licensed Embalmer No. *4329*

P. O. Address *St. Louis, 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.