

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3645

State File No.

FILED JAN 28 1953

318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 0068

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS.</u>		2169	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3501² Pestalozzi St.</u>				d. STREET ADDRESS (If rural, give location) <u>16 3501² Pestalozzi St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ELLA</u> b. (Middle) <u>K.</u> c. (Last) <u>REDHOUSE</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 2 1953</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed 2</u>	8. DATE OF BIRTH <u>APR 14 1886</u>		9. AGE (in years last birthday) <u>66</u>	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>ST. LOUIS, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>William Brant</u>		13b. MOTHER'S MAIDEN NAME <u>Emilie Mueller</u>		14. NAME OF HUSBAND OR WIFE <u>Frederick W^m Redhouse</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>John R. Kauffmann 408 Olive St.</u>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Chr. Myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 mths</u> <u>8 year</u> <u>6 year</u>	
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? <u>331X</u>			
22. I hereby certify that I attended the deceased from <u>Jan 21</u> , 19 <u>51</u> , to <u>12/29</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>12/21</u> , 19 <u>52</u> , and that death occurred at <u>12 Noon</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>H. W. Olshelford</u> (Degree or title) <u>MD</u>				23b. ADDRESS <u>3903 Olive</u>		23c. DATE SIGNED <u>1/3/53.</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Jan. 5, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Concordia</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>JAN 5 1953</u>		REGISTRAR'S SIGNATURE <u>J. C. Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>BEIDERWIEDEN F.H. Inc., 1936 ST. LOUIS AV.</u>			

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

(Licensed Embalmer's Statement on Reverse Side)

Dr. H. H. Shackelford
3903 Olive St.,
Ring' bell 2 times
1:15 P. M.

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

Max L. Clough

Licensed Embalmer No. 4170

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.