

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26304

State File No. \_\_\_\_\_  
Registrar's No. 6839

FILED JUL 31 1953

318

1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town or township) St Louis		c. LENGTH OF STAY (in this place) over 25 yrs	c. CITY OR TOWN St Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION 4063 W Belle Pl.		STREET ADDRESS (If rural, give location) 4063 W Belle Pl.	
3. NAME OF DECEASED (Type or Print) a. (First) Sylvester R. b. (Middle) ELLIS c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) 7-7-53	
5. SEX M	6. COLOR OR RACE COL	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 1-14-??
9. AGE (In years last birthday) 76	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pullman Porter	10b. KIND OF BUSINESS OR INDUSTRY none	9. AGE (In years last birthday) 76
11. BIRTHPLACE (City and State or Foreign Country) Homer, LA.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13a. FATHER'S NAME Ephriam ELLIS	13b. MOTHER'S MAIDEN NAME CLARA
14. NAME OF HUSBAND OR WIFE Emma ELLIS	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Emma Ellis - 4063 W. Belle
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis  Cerebral hemorrhage  II. OTHER SIGNIFICANT CONDITIONS None  DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH one day 4 months
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) 331X	
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?	
22. I hereby certify that I attended the deceased from 3-20-53, 10 P., to 7-7-53, 19, that I last saw the deceased alive on 7-7-53, 19, and that death occurred at 6 P., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Walter J. Sporeman		23b. ADDRESS 15 St. Louis	23c. DATE SIGNED July 10, 1953
24a. BURIAL OR CREMATION (Specify)	24b. DATE 7-11-53	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St Louis County, Mo
DATE REC'D BY LOCAL REG. JUL 11 1953	REGISTRAR'S SIGNATURE Earl Smith md NJK	25. FUNERAL DIRECTOR'S SIGNATURE A. L. Beal Und. - 4303 Delmar	

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

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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.....  
Signature of Student Embalmer

Signed *Daniel W. Hughes*.....

Licensed Embalmer No. *4803*.....

P. O. Address *3123 Rollen*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.