

FILED MAR 29 1957

 THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

11625

STATE FILE NUMBER

 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 227

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY		St. Louis		a. STATE		Missouri	
b. CITY (If outside corporate limits, give TOWNSHIP only)		Lemay		b. COUNTY		St. Charles	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		St. Rose Hospital		c. CITY OR TOWN		St. Peters 0920	
Length of stay in lb		3 mo.		d. STREET ADDRESS		1 Mile So. City Limits	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First		Middle		Last		Month Day Year	
Joseph		Ferd		Ell		March 16, 1957	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Sept. 8, 1892	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months Days Hours Min.	
64							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)	
Factory Worker				Automotive		St. Peters, Mo. 0	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Anton Ell				Anna Ernst			
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 Address	
No				490-28-5145		Mathilda Ell, St. Peters, Mo.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:							3 days
IMMEDIATE CAUSE (a) <u>Cardiac failure</u>							1 year
DUE TO (b) <u>Cor Pulmonale</u>							several years
DUE TO (c) <u>Pulmonary Emphysema</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED?
<u>Pulmonary Tuberculosis</u>							YES <input type="checkbox"/> NO <input type="checkbox"/> 0
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from <u>December 1, 1956</u> to <u>March 16, 1957</u> and last saw <u>him</u> alive on <u>March 16, 1957</u> . Death occurred at <u>10:30 pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title)				22b. ADDRESS		22c. DATE SIGNED	
<u>David Hafe Kerr, M.D.</u>				<u>950 Francis Pl., Clayton, Mo.</u>		<u>3/18/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Removal		3-20-57		All Saints Cemetery		St. Peters, Mo.	
24. FUNERAL DIRECTOR ADDRESS				25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE	
Albert H. Hoppe, 4700 Washington Blvd.				3/18/57		<u>Herbert A. Dombke MD</u>	

(Licensed Embalmer's Statement on Reverse Side)

87

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

Health, Welfare Public Service

 800  
 756

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

a. Name of Deceased: \_\_\_\_\_  
 b. Date of Death: \_\_\_\_\_  
 c. Place of Death: \_\_\_\_\_  
 d. Age of Deceased: \_\_\_\_\_  
 e. Sex: \_\_\_\_\_  
 f. Race: \_\_\_\_\_  
 g. Cause of Death: \_\_\_\_\_  
 h. Manner of Death: \_\_\_\_\_  
 i. Name of Physician: \_\_\_\_\_  
 j. Name of Hospital: \_\_\_\_\_  
 k. Name of City: \_\_\_\_\_  
 l. Name of State: \_\_\_\_\_

**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 Etienne P. Remelien

Licensed Embalmer No. 428

P. O. Address St. Louis

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.