

Health,
Welfare
Public
Service

FILED MAY 8 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-016564
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4722

300
-57

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, give TOWNSHIP only) <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>HOSPITAL OR INSTITUTION 4449 Delor St.</u>		d. STREET ADDRESS (If outside, give location) <u>4449 Delor St.</u>	
Length of stay in 1b		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>P.</u> Last <u>ULLRICH</u>			4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1958</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <u>2</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 24, 1877</u>
9. AGE (In years last birthday) <u>81</u>		10. USUAL OCCUPATION (Give kind of work done usually or last, even if retired) <u>Housework</u>	11. BIRTHPLACE (City and state or country) <u>Germany</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Frank Ellensohn</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Late Casper Ullrich</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Marie Rolf 9813 Scottdale(21)</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis with</u> DUE TO (b) <u>hypertension</u> DUE TO (c) <u>left cardiac failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Nov. 1948</u> <u>3-4 days</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? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.) <u>443x</u>		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	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>Nov. 7-1948</u> to <u>May 1/58</u> and last saw her alive on <u>5-1-58</u> . Death occurred at <u>7:00 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>O. C. [Signature]</u>		22b. ADDRESS <u>4523 S Kingshighway</u>	22c. DATE SIGNED <u>5-1-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>May 3, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u>	23d. LOCATION (City, town or county) (State) <u>St. Louis Co. Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Kriegshauser 4228 S. Kingshighway</u>		25. DATE RECD. BY LOCAL REG. <u>MAY 2 1958</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 Richard W. Storvick

Licensed Embalmer No. 4007

P. O. Address

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.