

**FEDERAL BUREAU OF INVESTIGATION - UNITED STATES DEPARTMENT OF JUSTICE**

**U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-003353**

**FILED VS JAN 22 1960**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 276**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St Louis Mo.</b>		a. STATE <b>Mo.</b>	b. COUNTY
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>221 Robert Ave.</b>		c. CITY OR TOWN <b>St Louis</b>	d. STREET ADDRESS (If outside, give location) <b>221 Robert Ave.</b>
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>Ida Ellegood</b>	4. DATE OF DEATH Month <b>January</b> Day <b>6</b> Year <b>1960</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/15/1880</b>	9. AGE (last birthday) <b>79</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>	11. BIRTHPLACE (City and state or country) <b>Illinois</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Jacob Krantz</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Kaufmann</b>	14. NAME OF HUSBAND OR WIFE <b>James Rd.</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT <b>Frieda Schmidt</b>	Address <b>4424 Butler Hill</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b>		<b>1 day</b>
DUE TO (b) <b>arterio-sclerotic heart</b>		<b>2 yrs</b>
DUE TO (c) <b>disease with hypertension</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic cholecystitis</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year
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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
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21. I attended the deceased from <b>Jan 6, '60</b> to <b>Jan 6, '60</b> and last saw her alive on <b>Jan 6 - '60</b>
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Death occurred at <b>8 15 p.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>George A. O'Sullivan, M.D.</b>	22b. ADDRESS <b>7629 Ivory Ave.</b>	22c. DATE SIGNED <b>1-8-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>1/11/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mo. Hope Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Lemay Mo.</b>
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24. FUNERAL DIRECTOR <b>JOS. P. FENDLER JR. 7128 MICHIGAN</b>	25. DATE RECD. BY LOCAL REG. <b>JAN 9 1960</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b>
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BY AFFIDAVIT OF MEDICAL CERTIFICATION

DOCUMENT  
1-8-60

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Clarence Kach

Licensed Embalmer No. 3093

P. O. Address 7148 7th

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.