

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-044455

FILED VS NOV 2 8 1960

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 3409

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkwood</u>	Length of stay in lb <u>7 weeks</u>	c. CITY OR TOWN <u>Glendale</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>832 Queen Anne Place</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>ELY</u> Last			4. DATE OF DEATH Month <u>Nov.</u> Day <u>23</u> Year <u>1960</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/25/1871</u>	9. AGE (last birthday) <u>89</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Education</u>	11. BIRTHPLACE (City and state or country) <u>Mount Carmel, Ill</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Joseph H. Ely</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Lynk</u>		14. NAME OF HUSBAND OR WIFE <u>Never Married</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>None</u>	17. INFORMANT Address <u>Frank M. Ely, Brookfield, Illinois</u>		

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) <u>Cerebral embolism</u>		<u>38 days</u>
DUE TO (b) <u>Myocardial infarction due to arterio-sclerotic heart disease with auricular fibrillation</u>		<u>48 days</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Embolism of popliteal artery with gangrene of right lower extremity.</u>		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
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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.)
20c. TIME OF INJURY Hour Month, Day, Year 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
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21. I attended the deceased from Oct. 4, 1960 to Nov. 23, 1960 and last saw her alive on Nov. 22, 1960
Death occurred at 8:45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Physician or other qualified person) <u>Philip P. Dojan, M.D.</u>	22b. ADDRESS <u>714 S. Kirkwood Rd. Kirkwood 22, Mo.</u>	22c. DATE SIGNED <u>11-23-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11-24-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bronswood Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Hinsdale Ill.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Parker-Aldrich, Webster Groves, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11-24-60</u>	26. REGISTRAR'S SIGNATURE <u>Joseph M. Ely, M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Leslie Welch

Licensed Embalmer No. 439

P. O. Address Wahpeton

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.