

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046257

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11543 STATE FILE NUMBER

FILED DEC 18 1961

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) OR TOWN <u>St. Louis</u>		Length of stay in lb <u>44 yrs. 1 mo;</u> <u>11 days.</u>	c. CITY OR TOWN <u>St. Louis</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. Louis State Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2334 S. Compton</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM ELLERSICK</u>			4. DATE OF DEATH Month Day Year <u>December 10, 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>1-30-95</u>	9. AGE (last birthday) <u>66 yrs.</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>formerly: Clerical</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Charles Ellersick</u>		13b. MOTHER'S MAIDEN NAME <u>Augusta Lohmar</u>		14. NAME OF HUSBAND OR WIFE <u>---</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.	17. INFORMANT <u>St. Louis State Hospital Records</u> Address
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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)	<u>Acute Pulmonary infarction, bilateral</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Acute pulmonary embolism, bilateral</u> DUE TO (c) <u>Thrombosis of femoral and tibial veins</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <u>466x</u> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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	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 <u>Dec. 29, 1916</u> to <u>Dec. 10, 1961</u> and last saw him alive on <u>Dec. 10, 1961</u> Death occurred at <u>7:15 p.m.</u> 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) <u>R. Hoplaes M.D.</u>	22b. ADDRESS <u>5400 Arsenal St.</u>	22c. DATE SIGNED <u>12-11-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>	23b. DATE <u>12-12-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Missouri Crematory</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
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24. FUNERAL DIRECTOR <u>John L. Ziegenhein &amp; Sons</u> ADDRESS <u>7027 Gravois</u>	25. DATE RECD. BY LOCAL REG. <u>DEC 12 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loed Smith, M.D.</u>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**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 Dorinda King

Licensed Embalmer No. 4563

P. O. Address James St

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.