

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

38992

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City St. Louis (No. City Hospital)

File No.

Registered No. 11469

12029 St. (No. City Hospital) St. (Ward)

2. FULL NAME

(a) Residence. No. 4643 Mc Caffery St Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Marie Scheller

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 5-1866

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<u>63</u>	<u>5</u>	<u>16</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Clerk
(b) General nature of industry, business, or establishment in which employed (or employer). Office
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER John W. Scheller

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Elizabeth Hart

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ireland

14. Hospital Information INFORMANT C. Power
(Address) City Hospital

15. NOV 23 1929 FILED 19 C. H. H. H.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 21 1929

17. I HEREBY CERTIFY, That I attended deceased from Nov. 2nd, 1929, to Nov. 21, 1929 that I last saw h. alive on Nov. 21st, 1929, and that death occurred, on the date stated above, at 10:50 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Diabetic Gangrene of Right leg '29
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 57
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) J. H. H. H. M. D.

11/21, 1929 (Address) City Hospital
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary DATE OF BURIAL 11-25 1929

20. UNDERTAKER Arthur J. Hornsby ADDRESS 2039 Wash St

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

15-10-253

