

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

**5122**  
Do not use this space.

REC'D MAR 14 1938

**1. PLACE OF DEATH**

(a) County..... Registration District No. **791**  
 (b) Township..... Primary Registration District No. **1003**  
 (c) City **St. Louis** (d) Street No. **City Hospital No. 1** Registered No. **1767**  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME**

**Chorline Scheller 460**  
 (a) Residence, No. **2816 Lyon** St. **24** (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX **female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **single**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **2/18/38**, 19

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

22. I HEREBY CERTIFY, That I attended deceased from **12/4/36** to **2/18/38**, 19  
 I last saw her **2/18/38** alive on **2/18/38**, 19. Death is said to have occurred on the date stated above, at **4.10** a.m.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **JULY 31st 1937**  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**0 6 18**

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as a sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. **nil**  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

*Chitis media - Bilateral  
 Post auricular abscess - left  
 Septicemia (Sharp looking  
 Thrombolytic)*  
 Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, Missouri**

Other contributory causes of importance: **gga**

FATHER 13. NAME **Philip Scheller**

Name of operation **Bilateral Anthrotomy** date of **2-7-38**

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, Missouri**

What test confirmed diagnosis? Was there an autopsy? **Yes**

MOTHER 15. MAIDEN NAME **Eana Aubrey**

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? Date of injury, 19

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, Missouri**

Where did injury occur? (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT (ADDRESS) **Hosp. Info M. Kent**

Manner of injury  
 Nature of injury

18. BURIAL, CREMATION, OR REMOVAL PLACE **ST. TRINITY LUTH CEM** DATE **FEB 19 1938**

24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify

19. FUNERAL DIRECTOR (ADDRESS) **E. J. Schurr, 3125 Lafayette Ave.**

(Signed) **F. W. Siegel**, M. D.  
 (Address) **City Hospital No. 1**

20. FILED **FEB 19 1938** Local Registrar

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

STATEMENT BY LICENSED EMBALMER

I, Joseph Kollmer, Licensed Embalmer No. 4014  
hereby certify that the body recorded on the reverse side of this certificate was embalmed by Joseph Kollmer  
L. E.

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed Joseph Kollmer  
Licensed Embalmer No. 4014

**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.)**