

1939

REC'D MAR 9 1939

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

7824

Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis, Registration District No. 784
(b) Township Richmond Heights Primary Registration District No. 111 Registered No. 358
(c) City Richmond Heights (d) Street No. St. Mary's Hosp. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(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

Mathias H. Selig,
(a) Residence, No. 1241 Hamilton Ave. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 19, 1885

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
53 3 7

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

FATHER 13. NAME Henry Selig.
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER 15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT Otto Reinert,
(ADDRESS) 5475 Cabanne Ave.

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary DATE 3/1/1939

19. FUNERAL DIRECTOR (NAME) W. A. Stock Und. Co
(ADDRESS) 2117 E. Grand Blvd

20. FILED 2117 E. Grand Blvd
Local Registrar.

FEB 27 1939

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 26, 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 19, 1939, to Feb 26, 1939
I last saw him alive on Jan 26, 1939 Death is said to have occurred on the date stated above, at 12:30 P. M.

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

Acute Medullary Date of onset
Oedema - Respiratory failure

Other contributory causes of importance:

Stroma of Right Temporal
Similar Soft of Cerebrum

Name of operation 2/20/39 Craniotomy
What test confirmed diagnosis? Was there an autopsy? Yes

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

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

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify (Signed) W. A. Stock M. D.

(Address) Community Club Bldg.

547

~~W. E. C. Fennell~~

~~4101 Fostede~~

July 26th

P

6125 Marlboro

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

Registered Apprentice No., working under my personal supervision.

Signed

Frank A. Moore

Licensed Embalmer No.

3041

P. O. Address

2117 E. Main

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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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7824
Do not use this space.

1. PLACE OF DEATH

(a) County St Louis Registration District No. 784
 (b) Township Richmond Hts Primary Registration District No. 111 Registered No. 358
 (c) City Richmond Hts (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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

(a) Residence, No. _____ St. Mathias H. Selig
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) s.
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
 7. AGE YEARS 33 MONTHS 3 DAYS 7 If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 FATHER
 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 MOTHER
 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 17. INFORMANT (ADDRESS) _____
 18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19.
 19. FUNERAL DIRECTOR (ADDRESS) _____
 20. FILED 227 19 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 26 1939
 22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____
 I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:
acute medullary
Oedema Respiratory
Failure 5 H A
 Date of onset _____
 Other contributory causes of importance:
Glioma of right temporal frontal lobe of cerebrum
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) James F. Quay, M. D.
 (Address) Richmond Hts

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

CLOSE OR DESTROY IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Local Registrar.

