

APR 12 1939

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

8385
Do not use this space.
2150

1. PLACE OF DEATH

(a) County St. Louis Missouri Registration District No. 791
 (b) Township St. Louis Missouri Primary Registration District No. 1003 Registered No. 2150
 (c) City St. Louis Missouri (d) Street No. Luthern Hospital 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. 202 Frank Andrew Scego St. NR Oak Hill, Mo.
 (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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 30, 1893

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
45 3 4

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farming
 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) Rosebud Mo.

FATHER 13. NAME Thomas Scego

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Washington Mo.

MOTHER 15. MAIDEN NAME Katherin Rapier

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Poland

17. INFORMANT (ADDRESS) Mary Scego Oak Hill, Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE Owensville Mo. DATE March 7, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Albert H. Hoppe Inc. 4700 Washington Blvd.

20. FILED MAR 6 1939 J. F. Brudner Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-4-39 19

22. I HEREBY CERTIFY, That I attended deceased from 2-23-39, 19, to 3-4-39 19

I last saw him alive on 3-3-39 19. Death is said

to have occurred on the date stated above, at 525 A St.
 The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage
and left Hemiplegia
chronic hypertensive

Date of onset

3-1-39

Other contributory causes of importance:

Name of operation _____ Date of _____
 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) Thos. H. Hansen, M. D.
 (Address) 3657 Grandview Ave

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.

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..... *J. G. Sullivan*.....

Licensed Embalmer No. *1122*.....

P. O. Address *4700 Washington Bldg*.....

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.