

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12449

Registration District No. 784

Primary Registration District No. 116

Registrar's No. 581

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town University City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
6965 Pershing Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
(Specify whether
In this community 35 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town University City
(If outside city or town limits, write "RURAL")
(d) Street No. 6965 Pershing Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

8. (a) PRINT FULL NAME MINNIE DOLORES SCHELL

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Robert C. Schell 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased October 1 1879
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 5 21 _____ hr. _____ min.

9. Birthplace Greencastle Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Wallace Johnston 13. Birthplace Windsor Ontario
(City, town, or county) (State or foreign country)

14. Maiden name Minnie D. Johnston Crawford
15. Birthplace Greencastle Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Robt C. Schell

(b) Address 6965 Pershing Ave.

17. (a) burial (b) Date thereof 3/25/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lake Charles

18. (a) Signature of funeral director Alexanders Sons

(b) Address 6175 Delmar Blvd

19. (a) _____ (b) R. Mays
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 22nd,
year 1940 hour 12 noon minute _____ M.

21. I hereby certify that I attended the deceased from 9/11/39
_____, 19____, to 3/22/40, 19____;
that I last saw her alive on 3/22/40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis
Hypertensive heart disease
Due to _____

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations 93
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature James M. Martin (M. D. or other) _____

Address 607 - 7th road Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.

WHILE I REMAIN—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1 10981

APR 1 1946

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.....

Albert C. White....., Registered Apprentice No. 209

working under my personal supervision.

Signed Joe. E. McCulloh.....

Licensed Embalmer No. 2460

P. O. Address 6170 Delmar

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.