

Registration District No. **317**

Primary Registration District No. **6076**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Wellston**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
6425 Mount Avenue
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **Wellston**
(If outside city or town limits, write "RURAL")
(d) Street No. **6425 Mount Avenue**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Lela E. Schubert**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Fred Schubert** 6. (c) Age of husband or wife if alive **64** years

7. Birth date of deceased **October 3, 1889**
(Month) (Day) (Year)

8. AGE: Years **55** Months **1** Days **0** If less than one day _____ hr. _____ min.

9. Birthplace **Waverly Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **Alexander Hart**

13. Birthplace **Illinois**
(City, town, or county) (State or foreign country)

14. Maiden name **Hulda McClain**

15. Birthplace **Illinois**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Fred Schubert**

(b) Address **6425 Mount Avenue**

17. (a) **Burial** (b) Date thereof **11/4/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Peter's Cemetery**

18. (a) Signature of funeral director **Shepard Funeral Home**

(b) Address **1167 Hamilton Avenue**

19. (a) **NOV 4 1944** (b) **E. Y. Moller**
(Date received local registrar) (Registrar's signature) Address **4439 San Francisco** Date signed **11/4/44**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **2** nd
year **1944** hour **1** minute **50** **MA**

21. I hereby certify that I attended the deceased from **Oct 19 1944**
to **Nov 2 1944**
that I last saw h. ~~er~~ alive on **Oct 31** 1944
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage**
Due to **Arteriosclerosis** ?
Duration **10 days**

Due to **830-1**
Other conditions _____
(Include pregnancy within 5 months of death)

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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 **3**
23. Signature **A. J. Thompson** (M. D. or other) _____
Address **4439 San Francisco** Date signed **11/4/44**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

16
9
0

NOV 28 1944

DEC 1 1944

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 W. W. Wilkinson

Licensed Embalmer No. 3575

P. O. Address.....

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, fact should be so stated above.