

FILED MAY 26 1945
Registration District No. **318**

Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4735 Penrose St.
(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 _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4735 Penrose St.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Selma Henrietta Schaaless**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Henry Schaaless** 6. (c) Age of husband or wife if alive **67** years
7. Birth date of deceased **March 28th, 1879**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
66 **1** **13** hr. _____ min.

9. Birthplace **St. Louis, Mo.**
(City, town, or county) (State or foreign country)
10. Usual occupation **Housewife**

11. Industry or business
12. Name **Ernest Klockenbrink**
13. Birthplace **Germany**
(City, town, or county) (State or foreign country)
14. Maiden name **Hannah Obermeier**
15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Henry Schaaless**
(b) Address **4735 Penrose St.**
17. (a) **Burial** (b) Date thereof **5-15-45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Johns Cemetery**

18. (a) Signature of funeral director **Provost Und. Co.**
(b) Address **3710 N. Grand Bl**
19. (a) **MAY 15 1945** (b) **J. F. Bredek**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **14th**
year **1945** hour **10.30** minute **P.** M.
21. I hereby certify that I attended the deceased from **Feb 1945** to **May 11 1945**
that I last saw her alive on **May 11 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **General Carcinomatosis** Duration **16 mo**
Due to **Ca Uterus** **16 mo**
Hypertension Cardio Vascular Renal **7 yrs**
Other conditions: **Chronic Lymphatic Leukemia** **4 yrs**
(Include pregnancy within 3 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)
(c) Means of injury _____
23. Signature **O. A. Lindeman** (M. D. or other) **210**
Address **4176 1/2 Shreve Ave** Date signed **5/12/45**

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.....

Paul E. Powell
Licensed Embalmer No. 1578

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.