S. No. 2
DM—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JUL 20 1945

State File No. 25095

Registration District No. 317 Primary Registration District No. 30206076 Registrar's No. 1875

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Pine Lawn
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3330 Lucas & Hunt Road
(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 Mo (b) County St. Louis
(c) City or town Pine Lawn
(If outside city or town limits, write "RURAL")
(d) Street No. 3330 Lucas & Hunt Road
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Joseph A. Scheller
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Rose Scheller
6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased 10 (Month) 19 (Day) 1876 (Year)

8. AGE:	Years	Months	Days	If less than one day
	68	8	25	hr. ..... min.

9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Plumbers Supply Salesman
11. Industry or business .....
FATHER
12. Name John Scheller
13. Birthplace Unknown (City, town, or county) Pennsylvania (State or foreign country)
MOTHER
14. Maiden name Elizabeth Hart
15. Birthplace ..... (City, town, or county) Ireland (State or foreign country)
16. (a) Informant Mrs. Rose Scheller
(b) Address 3320 Lucas & Hunt Road
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-17-45 (Month) (Day) (Year)
(c) Place: burial or cremation Bellefontaine Cemetery
18. (a) Signature of funeral director Arthur J. Donnelly
(b) Address 3840 Lindell Blvd.
19. (a) 7-16-45 (Date received local registrar) (b) E. G. McGovern MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14th year 1945 hour 9 minute 45 A. M.
21. I hereby certify that I attended the deceased from March 17, 1941, to July 14, 1945 that I last saw him alive on July 13, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary Thrombosis	10 hrs
Due to Congestive Heart Failure	4 months
Due to Coronary Arteriosclerosis	4 years
Other conditions (Include pregnancy within 3 months of death)	

94a

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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....
23. Signature James H. Cummings (M. D. or other)
Address 444 N. Euclid Av. Date signed 7/14/45

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(Licensed Embalmer's Statement on Reverse Side)

JUL 23 1945

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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lindell

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.