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 SEP 7 1945

26099

State File No. C

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 2587

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: City Sanitarium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15yrs 11mos 22ds. (Specify whether
In this community 40 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. ~~3505 Easton~~ Aye 4/3
City Sanitarium (If usual, give location)

(e) Citizen of foreign country? Yes (Yes or No)

If yes, name country Ireland

3. (a) PRINT FULL NAME MARY HOOPE SCHELLIS

3. (b) If veteran, name war

3. (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 Jack Schellis

6. (c) Age of husband or wife if alive years

7. Birth date of deceased August (Month) 23 (Day) 1876 (Year)

8. AGE: Years 69 | Months 0 | Days 3 | If less than one day hr. min.

9. Birthplace not known (City, town, or county) Ireland (State or foreign country)

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name not known
13. Birthplace not known (City, town, or county) Ireland (State or foreign country)

MOTHER
14. Maiden name not known
15. Birthplace not known (City, town, or county) Ireland (State or foreign country)

16. (a) Informant Thelma A Singler
(b) Address 5400 Arsenal St.

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Thos J Fruan
(b) Address 1519 S Grand Boulev

19. (a) AUG 29 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 26th year 1945 hour 11:40 minute P.M.

21. I hereby certify that I attended the deceased from July 7, 1944 to August 26, 1945 that I last saw her alive on August 26, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary Occlusion	2 days
Acute Cardiac Decompensation	
Due to with Pulm. Edema	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

95

Major findings:
Of operations

Of autopsy No

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 L Kerschbaumer M.D. (M. D. ~~or other~~)

Address 5400 Arsenal St Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Ronald O Yahnke

Licensed Embalmer No. P3917

P. O. Address St Louis

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.