S. No. 2
M—8-43
. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED DEC 28 1945

Registration District No. 518 Primary Registration District No. 1003

State File No. 39777

Registrar's No. 10984

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
5217 Goodfellow
(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. 5217 Goodfellow
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME JOSEPHINE MARY SCULLY

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 widow

6. (b) Name of husband or wife

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

7. Birth date of deceased April (Month) 20th (Day) 1876 (Year)

8. AGE: Years 69 Months 7 Days 26 If less than one day hr. min.

9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Julius Lehmann
13. Birthplace St. Louis, Mo
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name unknown
15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Rose Seitz
(b) Address 5217 Goodfellow

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 12-19-45 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Sullivan Brothers,
(b) Address 2849 North Euclid Avenue,

19. (a) DEC 17 1945 (Date received local registrar) J. F. Bradeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 16th year 1945 hour 4:00 minute A. M.

21. I hereby certify that I attended the deceased from July 1 1945, 19 , to Dec 16, 1945 that I last saw her alive on Dec 16 45, 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Decompensated Heart	6 mo
Bright Disease	6 mo
Due to Mitar Regurgitation	6 mo
Due to Ob nephritis	16 mo

Other conditions
(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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address 1878 Madison Date signed 1/4/45

(Licensed Embalmer's Statement on Reverse Side)

Dr. Bernard Striegel
1875 Madison

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 Henry M. Brammer

Licensed Embalmer No. 4200

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.