

No. 2  
-5-43  
-17-39  
X36671

**FILED NOV 7 1946**

Registration District No. \_\_\_\_\_

Primary Registration District No. **1003**

**1003**

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

1. PLACE OF DEATH:

(a) County **St. Louis**

(b) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Barnes Hospital**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **5 Weeks**  
(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. **4123 Pennsylvania**  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Lavinia HUNT Schelse**

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex **F** / Color or race **W**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Walter Schelse**

6. (c) Age of husband or wife if alive **45** years

7. Birth date of deceased **Nov 24 1902**  
(Month) (Day) (Year)

8. AGE: Years **43** Months **10** Days **29** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation **House Wife**

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name **Jacob Hoffmann**

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

14. Maiden name **Kessler Katherine**

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

16. (a) Informant **Walter Schelse**

(b) Address **4123 Pennsylvania**

17. (a) **Burial** (b) Date thereof **Oct 25 1946**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Park Lawn Cemetery**

18. (a) Signature of funeral director **Wm Schumacher**

(b) Address **3013 Meramec st.**

19. (a) **OCT 24 1946** (b) **J. F. Bredeck**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **23**  
year **1946** hour **I** minute **30** P M.

21. I hereby certify that I attended the deceased from **Sept 7 1946** to **Oct 23 1946**  
that I last saw him **alive on Oct 22 1946**  
and that death occurred on the date and hour stated above.

Immediate cause of death **shuntite heart disease several years**

Duration \_\_\_\_\_ years

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

95

PHYSICIAN

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 **Walter Schelse** (M. D. or other) \_\_\_\_\_

Address **St. Louis, Mo** Date signed **10-24-46**

Dr Luten  
3720 Washington

Thur. 2-6

JE-2866

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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 Francis Williamson

Licensed Embalmer No. 3565

P. O. Address St Louis Mo

**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.