No. 2
1/47
7-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 11 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33010

Registration District No. 318 — Primary Registration District No. 1003 — Registrar's No. 9142

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: 407 LUCAS (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County
(c) City or town ST. LOUIS (If outside city or town limits, write "RURAL")
(d) Street No. 5837 Devonshire (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME DR. THOMAS M. SELLARS
3. (b) If veteran, name war WORLD WAR I
3. (c) Social Security No.
4. Sex MALE
5. Color or race W.
6. (a) ~~Single~~, widowed, married, divorced MARRIED
6. (b) Name of husband or wife ESTHER M. SELLARS
6. (c) Age of husband or wife if alive years
7. Birth date of deceased APRIL (Month) 13 (Day) 1899 (Year)

8. AGE: Years	Months	Days	If less than one day
48	5	18	hr. min.

9. Birthplace MISSOURI (City, town, or county) (State or foreign country)
10. Usual occupation OPTOMETRISTS
11. Industry or business
FATHER 12. Name Dr. THOMAS M. SELLARS
FATHER 13. Birthplace COLUMBUS Ohio (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name MARTIE MOOR
MOTHER 15. Birthplace Mo. (City, town, or county) (State or foreign country)
16. (a) Informant Mrs Esther M. Sellars
(b) Address 5837 Devonshire Av
17. (a) BURIAL (Burial, ~~cremation, or removal~~) (b) Date thereof Oct 4-47 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ CALVARY cem
18. (a) Signature of funeral director E. J. Schnur
(b) Address 3125 Lafayette Av
19. (a) OCT 2 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 1, year 1947 hour 1 minute P.M.
21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw h alive on , 19; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Cerebral Hemorrhage
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

PHYSICIAN — Underline the cause of 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 (M. D. or other)
Address Date signed 10/2/47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

DEC 7 1984

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 Jos B Vollmer

Licensed Embalmer No. 4014

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.