

FILED OCT 28 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 35568

8975

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>2606 Rear S. Broadway</b>				d. STREET ADDRESS (If rural, give location) <b>2606 Rear S. Broadway</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>John</b> b. (Middle) _____ c. (Last) <b>Sellin</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>10/18/49</b>				
5. SEX <b>Male</b> <input checked="" type="checkbox"/>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Oct. 26, 1888</b>	
9. AGE (In years last birthday) <b>60</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Confectionary Business</b>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>Turkey</b> <input checked="" type="checkbox"/>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13a. FATHER'S NAME <b>Unknown</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>			14. NAME OF HUSBAND OR WIFE <b>Rose</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Ollie Scellin--2606 S. Broadway</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		<b>MEDICAL CERTIFICATION</b> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>Chronic Hypertension</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <b>none</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>none</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>St. Louis Missouri 92</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>B3IX</b>			
22. I hereby certify that I attended the deceased from <b>July 15, 1945</b> , to <b>Oct 18, 1949</b> , that I last saw the deceased alive on <b>10/16, 1949</b> , and that death occurred at <b>7:30 a. m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Dr. John B. Canepa M.D.</b>				23b. ADDRESS <b>2105 S. Broadway</b>		23c. DATE SIGNED <b>10/18/49</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>10/20/49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>New Picker Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>	
DATE REC'D BY LOCAL REG. <b>OCT 19 1949</b>		REGISTRAR'S SIGNATURE <b>J. B. Basator</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Wacker-Welderle 3634 Gravois</b>			

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

**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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed *Delis J. Krupine*

Licensed Embalmer No. 3497

P. O. Address 3634 Gravois

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.