

FILED JAN 10 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **43302**  
**04775**  
Registrar's No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **6076**

96 Oct

1. PLACE OF DEATH a. COUNTY <b>St Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo</b> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Ballwin</b>		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>Pine Crest No. 4</b>		d. STREET ADDRESS (If rural, give location) <b>4417 Westminster Dr</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Selle</b> b. (Middle) <b>Stanley</b> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <b>12-24-1949</b>		
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5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widow</b>		8. DATE OF BIRTH <b>3-26-1870</b>		9. AGE (In years last birthday) <b>79</b>		If UNDER 1 YEAR Months Days		If UNDER 24 HRS. Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>me</b>			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (State or foreign country) <b>Purico Mo</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
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13a. FATHER'S NAME <b>Samuel Curd</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Salomon</b>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Max Stanley</b> ADDRESS <b>St Louis Mo</b>	
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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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
		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) <b>Chronic Myocarditis</b>					
		DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				<b>422.2</b>	

19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	
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22. I hereby certify that I attended the deceased from **Nov 16, 1949**, to **12-24, 1949**, that I last saw the deceased alive on **12-24, 1949**, and that death occurred at **8:45 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>G.T. Merten M.D.</b> (Degree or title)		23b. ADDRESS <b>442 No 2 Taylor</b>		23c. DATE SIGNED <b>12-24-49</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>12-24-49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Unknown</b>		24d. LOCATION (City, town, or county) (State) <b>Advance Mo</b>	
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DATE REC'D BY LOCAL REG. <b>12-24-49</b>		REGISTRAR'S SIGNATURE <b>Herbert R. Dombke M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Rowland Mortuary Service Inc.</b> ADDRESS <b>4104 Manchester Ave. St. Louis 10, Mo.</b>	
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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.....

.....  
working under my personal supervision.

Student Embalmer No. ....

Student .....  
Student Embalmer

Signed

*J. Allen Davis*

Licensed Embalmer No. ....

P. O. Address

*453  
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.