

No. 300
10-48

FILED SEP 13 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28163
7486

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY ST. LOUIS	
b. CITY OR TOWN ST. LOUIS		c. CITY OR TOWN WEBSTER GROVES	
d. FULL NAME OF HOSPITAL OR INSTITUTION DEACONESS HOSPITAL		e. STREET ADDRESS (If rural, give location) 318 BAKER AVENUE	

3. NAME OF DECEASED (Type or Print) SARAH	a. (First)	b. (Middle) RUTH	c. (Last) SKELLY	4. DATE OF DEATH (Month) (Day) (Year) Aug 24, 1955.
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5. SEX Female.	6. COLOR OR RACE White.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married.	8. DATE OF BIRTH July 28, 1875.	9. AGE (In years last birthday) 80.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 2 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home.	10b. KIND OF BUSINESS OR INDUSTRY Housewife.	11. BIRTHPLACE (City and State or Foreign Country) Canada.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Unknown Houghton.	13b. MOTHER'S MAIDEN NAME Unknown.	14. NAME OF HUSBAND OR WIFE James W. Skelly.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) np.	16. SOCIAL SECURITY NO. none.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS James W. Skelly, #318 Baker Ave.,
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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, ashenia, 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) Arterio Sclerotic Cardio Vas Dis + Anomias of Liver		5 years
	II. OTHER SIGNIFICANT CONDITIONS Complete Heart Block + Herpes Zoster		4 years 2 mo

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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 447X
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22. I hereby certify that I attended the deceased from Nov, 1950 to 8/24, 1955, that I last saw the deceased alive on 8/24, 1955, and that death occurred at 3 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Carl Brand MD	23b. ADDRESS Webster Groves Mo	23c. DATE SIGNED 8/25/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 8/26/55	24c. NAME OF CEMETERY OR CREMATORY BELLEFONTAINE CEMETERY	24d. LOCATION (City, town, or county) (State) ST. LOUIS, MISSOURI
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DATE REC'D BY LOCAL REG. AUG 26 1955	REGISTRAR'S SIGNATURE J. Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. R. LUPTONS AND SONS 7233 DELMAR BLV'D
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD.

(Licensed Embalmer's Statement on Reverse Side)

18 to 10

OCT 10 1955

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.....
Signature of Student Embalmer

Signed *Arnold W. Schoene*

Licensed Embalmer No. *386*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.