

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015672

STATE FILE NUMBER  
2 4026

Health,  
Welfare  
Public  
Service

DECEASED MAY 11 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. \_\_\_\_\_

300  
-57  
25  
694

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>3226a Miami St.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle Last <b>SHELLENBERGER</b>			4. DATE OF DEATH Month <b>Apr.</b> Day <b>22</b> Year <b>1959</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 22, 1887</b>	9. AGE (In years last birthday) <b>71</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>Foreman-Mesker Iron Co.</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Christian S. Schellenberger</b>	13b. MOTHER'S MAIDEN NAME <b>Ottilia Weidenboerner</b>	14. NAME OF HUSBAND OR WIFE (Dec'd.) <b>Annie Schellenberger</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Gertrude Thorpe #18 S. Kingshighway</b> Address
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18. CAUSE OF DEATH (None only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SUBARACHNOID HEMORRHAGE - LEFT.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>GENERALIZED ARTERIO SCLEROSIS</b>	<b>20 YRS</b>
	DUE TO (c) <b>DIABETES MELLITUS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>ACUTE PULMONARY EDEMA - CARDIAC</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>260X</b>
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>St. Louis, Mo.</b>	COUNTY <b>St. Louis</b>	STATE
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21. I attended the deceased from <b>Nov. 29, 1958</b> to <b>Apr. 22, 1959</b> and last saw <sup>him</sup> alive on <b>Apr. 22, 1959</b> Death occurred at <b>11:20 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Joseph R. Muecke, M.D.</b> (Degree or title)	22b. ADDRESS <b>745 Missouri Heights Bldg.</b>	22c. DATE SIGNED <b>4/23/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or country) (State)
<b>Burial</b>	<b>Apr. 25, 1959</b>	<b>S/S Peter &amp; Paul Cem.</b>	<b>St. Louis, Mo.</b>

24. FUNERAL DIRECTOR <b>Kriegshauser 4228 S. Kingshighway</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>APR 24 '59</b>	26. REGISTRAR'S SIGNATURE <b>Lead Smith, M.D., P.P.</b>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

**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 *William D. White* .....

Licensed Embalmer No. *4391* .....

P. O. Address *2340 W. 11th St* .....

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.