

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS OCT 8 1959**

**59-034281**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. **8922**

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)			
a. COUNTY				a. STATE <b>Mo.</b>		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>			Length of stay in 1b	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>Deaconess Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4709 Clifton Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print)				<b>4. DATE OF DEATH</b>		<b>5. YEAR</b>	
First <b>DELLA</b>		Middle <b>E.</b>		Last <b>SCHEELER</b>		Month <b>Sep.</b>	Day <b>26</b>
Year <b>1959</b>	<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b>	<b>9. AGE</b> (last birthday) <b>75</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HR</b>
<b>Female</b>	<b>White</b>			<b>10-29-1883</b>		Months	Days
						Hours	Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housework</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>At Home</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Bath, Ill.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>
<b>13a. FATHER'S NAME</b> <b>George Dearing</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Nellie Shaw</b>			<b>14. NAME OF HUSBAND OR WIFE</b> <b>William J. Scheeler</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>			<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>William J. Scheeler</b> Address <b>4709 Clifton</b>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b>						<b>5 hrs</b>	
DUE TO (b) <b>Myo Cardial Infarction</b>						<b>5 days</b>	
DUE TO (c) <b>Arteriosclerotic Heart Dis.</b>						<b>several years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.	Month, Day, Year *						
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>	<b>STATE</b>
<b>21. I attended the deceased from</b> <b>June 1959</b> <b>10:30 P.</b> <b>to</b> <b>Sept 26 1959</b> <b>and last saw her</b> <b>Sept 26 1959</b> <b>alive on</b> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <b>Paul West MD</b>				<b>22b. ADDRESS</b> <b>4909 Lindenwood</b>		<b>22c. DATE SIGNED</b> <b>9/28/59</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>		<b>23b. DATE</b> <b>Sep. 29, 1959</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Sunset Burial Park</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Louis Co. Mo.</b>		
<b>24. FUNERAL DIRECTOR</b> <b>Kriegshauser 4228 S.Kingshighway</b>				<b>25. DATE RECD. BY LOCAL REG.</b> <b>SEP 28 59</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>Paul Smith, M.D.</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Edwin A. McNeill

Licensed Embalmer No. 3024

P. O. Address \_\_\_\_\_

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.