

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034831

FILED VS SEP 22 1959

Registration District No. 17 Primary Registration District No. 500 Registrar's No. 2457 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Saint Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Normandy		Length of stay in 1b 8 days	c. CITY OR TOWN Pacific Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Normandy Osteopathic		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 408 South 5th St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Irene Mae Schelling			4. DATE OF DEATH Month Day Year Sept. 12, 1959
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-1-1908
9. AGE (last birthday) 51		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (City and state or country) Saint Louis, Missouri
12. CITIZEN OF WHAT COUNTRY U S A		13a. FATHER'S NAME Ellsworth Mirgain	
13b. MOTHER'S MAIDEN NAME Junnie Dugan		14. NAME OF HUSBAND OR WIFE Walter Schelling	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	17. INFORMANT Address Walter Schelling-408 So. 5th -Pacific, Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO (b) Cerebral Hemorrhage DUE TO (c) Hyper tension Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 8 days 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Obesity (330 lbs +) Diabetic Mellitus			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from Sept 4, 1959 to Sept 12, 1959 and last saw her alive on Sept 11, 1959 Death occurred at 6:20 a m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) William D McEwan Jr		22b. ADDRESS 3301 Ashby Rd St Ann Mo	22c. DATE SIGNED 9/12/59
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE SEPT 15 1959	23c. NAME OF CEMETERY OR CREMATORY Good SHEPHERD CEM. HILLSBORO	23d. LOCATION (City, town, or county) (State) Mo
24. FUNERAL DIRECTOR Thomas Ruter 2906 Gravois	25. DATE RECD. BY LOCAL REG. 9-14-59	26. REGISTRAR'S SIGNATURE J. C. Murphy M.D.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1959 NOV 5 SA

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 *James C. Dill*

Licensed Embalmer No. *4347*

P. O. Address *2906 Fran*

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.