RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

LED VS FEB 23 1960 C 15170764 SL 22019

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1620-60-008821 STATE FILE NUMBER

NDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MO.
Length of stay in 1b: 21 DAYS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: VET ADM HOSPITAL
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI
b. COUNTY: Madison
c. CITY OR TOWN: MARQUAND
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): STAR ROUTE
Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First ROSCOE Middle CHARLES Last SCHELL

4. DATE OF DEATH: Month FEBRUARY Day 10 Year 1960

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 9-20-11
9. AGE (last birthday): 48
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): CREAM GRADER
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and state or country): MARQUAND, MISSOURI
12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: EUGENE SCHELL
13b. MOTHER'S MAIDEN NAME: BELLE SEABAUGH
14. NAME OF HUSBAND OR WIFE: ALBERTA SCHELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WWII
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: ALBERTA SCHELL, Address: STAR RT., MARQUAND, MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MYELOFIBROSIS OF BONE MARROW — INTERVAL BETWEEN ONSET AND DEATH: 1½ YEARS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): — — — —
DUE TO (c): — — 292.3 — —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PNEUMONIA RIGHT LOWER LOBE — —

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

I VA attended the deceased from 1-19-60 to 2-10-60 and last saw him alive on 2-10-60

Death occurred at 11:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: A. Fritsch (Degree or title) A. FRITSCH M.D.
22b. ADDRESS: VAH, ST. LOUIS, MO.
22c. DATE SIGNED: 2/11/60

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: 2/15/60
23c. NAME OF CEMETERY OR CREMATORY: NATIONAL CEMETERY
23d. LOCATION (City, town, or county) (State): JEFFERSON BARRACKS, MISSOURI

24. FUNERAL DIRECTOR ADDRESS: EDWARD FENDLER, 5611 SO. GRAND, ST. LOUIS,
25. DATE RECD. BY LOCAL REG.: FEB 11 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D. m

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed T. Q. Humphrey

Signature of Student Embalmer

Licensed Embalmer No. 4370

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.