N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D AUG 12 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

23690
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. 791

(b) Township ..... Primary Registration District No. 1003 Registered No. 6384

(c) City ST. LOUIS (d) Street No. 6215 WADE St.

(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME ELLA SCHOOR 600

(a) Residence, No. 6215 WADE St. 4

(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE

4. COLOR OR RACE: WHITE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*): MARRIED

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF HERMAN SCHOOR

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) JAN. 12, 1862

7. AGE: Years 76 Months 6 Days 4 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. RETIRED

9. Industry or business in which work was done, as saw mill, bank, etc. HOUSEWIFE

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation 0

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ST. LOUIS MO. U

FATHER

13. NAME WILLIAM FLUKES

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ENGLAND

MOTHER

15. MAIDEN NAME MARGARET ANDERSON

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) HOPKINSVILLE KENTUCKY

17. INFORMANT MRS. GEO. H. ALEXANDER (ADDRESS) 6215 WADE AVE. ST. LOUIS

18. BURIAL, ~~CREMATION, OR REMOVAL~~ PLACE BELLEFONTAINE DATE 7/18 1938

19. FUNERAL DIRECTOR (NAME) BAUMANN BROS. INC. (ADDRESS) 2504 WOODSON OVERLAND MO.

20. FILED JUL 17 1938 J. D. Bircher Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) JULY 16 1938

22. I HEREBY CERTIFY, That I attended deceased from July 1 1936 to July 16 1938

I last saw her alive on July 15 1938. Death is said to have occurred on the date stated above, at 4:30 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Myocarditis	5 yrs
Other contributory causes of importance:	
Chronic Interst. nephritis	5 yrs

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? NO

If so, specify .....

(Signed) J. H. Simons, M. D.

(Address) 4000 Chouteau Ave

(Licensed Embalmer's Statement on Reverse Side)

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 .....

Registered Apprentice No....., working under my personal supervision.

Signed Howard F Rowland

Licensed Embalmer No. 3114

P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.