

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-004078

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 871 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB
AMENDED

VS 300 Rev. 4/59	DATE AMENDED
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64	INSTEAD OF
	MEDICAL CERTIFICATION

FILED JAN 31 1963

1. PLACE OF DEATH
a. COUNTY Missouri b. CITY OR TOWN St. Louis

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in 1b 8 days

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital Inside Limits Yes No

d. STREET ADDRESS (If outside, give location) 46 Orchard Lane Reside on Farm Yes No

3. NAME OF DECEASED First OPAL Middle E. Last SCHELTINGA

4. DATE OF DEATH Month Jan. Day 25 Year 1963

5. SEX Female 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 3-13-1913 9. AGE (last birthday) 49

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (City and state or country) Shelbyville, Ill. 12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Edward Wyrick 13b. MOTHER'S MAIDEN NAME Estelle 14. NAME OF HUSBAND OR WIFE Andrew Scheltinga

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None 17. INFORMANT Kirkwood 22 Mo. Andrew Scheltinga-46 Orchard Ln.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular embolism
DUE TO (b) _____
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) myocardial infarct Nov. 1955
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 _____

21. I attended the deceased from 1947 to 1/25/63 and last saw her alive on 1/24/63
Death occurred at 7:00 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Joseph P. Kender M.D. 22b. ADDRESS 4511 Forest Park Blvd St. Louis 8 Mo 22c. DATE SIGNED 1/27/63

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE 1-28-1963 23c. NAME OF CEMETERY OR CREMATORY: Resurrection Cem. 23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.

24. FUNERAL DIRECTOR Pfztinger Mort-Kirkwood 22, Mo. ADDRESS _____ 25. DATE RECD. BY LOCAL REG. JAN 28 1963 26. REGISTRAR'S SIGNATURE Paul Smith, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

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 *Paul E. Selman*
Licensed Embalmer No. *4366*
P. O. Address *Howe, Me*

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.