LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County .....

Township ..... or Village ..... or City St Louis (NO. 5441 Dresden av St. 12 Ward)

Registration District No. ..... Primary Registration District No. .....

File No. 36823

Registered No. 9256

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Antonia Schiller

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX Female

4 COLOR OR RACE white

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) married

6 DATE OF BIRTH Oct. (Month) 3 (Day) 1857 (Year)

7 AGE 61 yrs. ..... mos. 2 ds. If LESS than 1 day, ..... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work House-work
(b) General nature of industry business, or establishment in which employed (or employer) at Home

9 BIRTHPLACE (City or town, State or foreign country) St Louis Mo

PARENTS

10 NAME OF FATHER Albert Chott

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Bohemia

12 MAIDEN NAME OF MOTHER Mary Kadlez

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Bohemia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Andrew Schiller

(Address) 5441 Dresden av

15 Filed OCT 7 1918 191 Max C Starkloff Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH Oct. (Month) 5 (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 5, 1918 (A.M.) to Oct 5th, 1918 (P.M.)

that I last saw her alive on Oct 5th, 1918

and that death occurred, on the date stated above, at 5 46 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage Apoplexy.

64

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ——

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Leo E. Wilucki M. D.

Oct 26, 1918 (Address) 5402 9 Dresden av

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL New Picker

DATE OF BURIAL Oct 8, 1918

20 UNDERTAKER [illegible] ADDRESS [illegible]

# LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

**1 PLACE OF DEATH**

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ..... St.: ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

**2 FULL NAME** .....

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.

**PERSONAL AND STATISTICAL PARTICULARS**

| 3 SEX | 4 COLOR OR RACE | 5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word) |
|---|---|---|
| | | |

6 DATE OF BIRTH

..... (Month) ..... (Day) ....., 1..... (Year)

7 AGE ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ..... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15

Filed ....., 191....., .....
Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH

..... (Month) ..... (Day) ....., 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....
that I last saw h..... alive on ....., 191.....
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death: ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

| 19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL |
|---|---|
| | ....., 191..... |
| **20 UNDERTAKER** | **ADDRESS** |
| | |

NENT RECORD