

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.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 791

32753

Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. 1003
(b) Township Primary Registration District No. 8807
(c) City St. Louis (d) Street No. City Hospital No. 1
(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

(a) Residence, No. 4408 Holly St. 9
(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 male 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 Auth Schiller. (Kling.)

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 19, 1889/

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
47 11. 1.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. T.R.R.A. yardman
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Missouri

13. NAME John F. Schiller.
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany.

15. MAIDEN NAME Wilhelmina Schultz.
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany.

17. INFORMANT Hosp. Info M. Kent (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Valhalla Crematory. Sept. 23, 1937.

19. FUNERAL DIRECTOR Math Hermann & Son. (ADDRESS) 2161 East Fair Ave.

20. FILE SEP 21 1937 J. F. Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/20/37 19

22. I HEREBY CERTIFY, That I attended deceased from 9/17/37 19 to 9/20/37 19
I last saw him alive on 9/20/37 19. Death is said to have occurred on the date stated above, at 9.10 a.m.
The principal cause of death and related causes of importance were as follows:

Internal Hydrocephalus Chronic

Other contributory causes of importance: 87B

Name of operation none Date of operation
What test confirmed diagnosis? Was there an autopsy? yes

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?
If so, specify
(Signed) M. A. Casberg M. D.
(Address) City Hospital No. 1

STATEMENT BY LICENSED EMBALMER •

I, Leonard J. Hampton, Licensed Embalmer No. 2967
hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

..... L. E.
No. or by Registered Apprentice No.
working under my personal supervision.

Signed Leonard J. Hampton
Licensed Embalmer No. 2967

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.)