

JAN 10 1938

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

42817
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....
(b) Township..... Primary Registration District No.....
(c) City St. Louis (d) Street No. DePaul Hospital
(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 Olga Schieler

(a) Residence, No. 3852a Ashland Ave. St. 10
(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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Fred H. Schieler</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Apr. 25, 1891</u>		
7. AGE	YEARS <u>46</u>	MONTHS <u>7</u>
	DAYS <u>5</u>	IF LESS than 1 day, hrs. or mln.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>At home</u>	
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>21</u>	
	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) <u>St. Louis Mo. 1</u>		
FATHER	13. NAME <u>Adolph G. Heiligstedt</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>St. Louis Mo. 1</u>	
MOTHER	15. MAIDEN NAME <u>Helen Keim</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Not known 41</u>	
17. INFORMANT (ADDRESS) <u>Adolph G. Heiligstedt 3852a Ashland Ave.</u>		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 29, 1937

22. I HEREBY CERTIFY, That I attended deceased from Nov 19, 1937, to Nov 29, 1937.

I last saw him alive on Nov 29, 1937. Death is said to have occurred on the date stated above, at 1:15 p. m.

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

Myocardial infarction
Chronic interstitial nephritis

Other contributory causes of importance: 121

Name of operation none Date of 5
What test confirmed diagnosis? pathology Was there an autopsy?

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) W Jackson Miller, M. D.
(Address) 4000 Old Bendy

18. BURIAL, CREMATION, OR REMOVAL
PLACE Mt. Lebanon Cem. DATE Dec. 2, 1937

19. FUNERAL DIRECTOR (ADDRESS)
Charles Brown Geneva Home 4911 Washington Blvd.

20. FILE DEC 1 1937 St. Bredeck
Local Registrar.

WHITE PRINT WITH OVERLAPPING INK---THIS IS A PERMANENT RECORD
 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.

STATEMENT BY LICENSED EMBALMER

I, William G. Bushko, Licensed Embalmer No. 2110

hereby certify that the body recorded on the reverse side of this certificate was embalmed by William G.

Bushko L. E.

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed William G. Bushko

Licensed Embalmer No. 2110

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.)