

No. 2  
1-14-41  
5-17-39  
X28390

Registration District No. 791 Primary Registration District No. 1003

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St Louis MO  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: BARNES HOSPITAL (1)  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Illinois (b) County Madison  
(c) City or town Frankfort (If outside city or town limits write "RURAL")  
(d) Street No. Road #1 (If rural, give location)  
(e) Citizen of foreign country? 2 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Emma Margaret Schillingew  
(b) If veteran, name war No  
(c) Social Security No. No

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May day 31  
year 1941 hour 5 minute 30 p. M.  
21. I hereby certify that I attended the deceased from 5-24-41  
1941 to 5-31- 1941  
that I last saw h. er alive on 5-31- 1941  
and that death occurred on the date and hour stated above.

4. Sex R 5. Color or race W  
6. (a) Single, widowed, married, divorced Married  
(b) Name of husband or wife Fred Schillingew  
(c) Age of husband or wife if alive 46 years  
7. Birth date of deceased August 31 1895  
(Month) (Day) (Year)

Immediate cause of death Uremia  
Hypertension  
Hypertensive Cardiovascular disease  
Due to Anemia, secondary  
Chronic nephritis  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

8. AGE: Years 45 Months 9 Days 0  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St Louis mo (1)  
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business Home

12. Name Richard Kramel

13. Birthplace Bromary 4  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Ann Schwamler

15. Birthplace Indiana 1  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. L. G. Deekham

(b) Address 6218 Julian

17. (a) Removal (b) Date thereof 6-1-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Johns East City, Ill

18. (a) Signature of funeral director E. J. Schildman

(b) Address Frank City, Ill

19. JUN 1 - 1941 (Date received local health officer) J. W. Deek (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature R. Williams (M. D. or other) 0  
Address BARNES HOSPITAL Date signed \_\_\_\_\_

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**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 E. H. Schildman

Licensed Embalmer No. 448

P. O. Address Granite City Ills

**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 this body is not embalmed, fact should be so stated above.**