

FILED OCT 18 1941

State File No.

7823

Registration District No.

Primary Registration District No.

1003

Registrar's No.

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
De Paul Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days 0

3. (a) PRINT FULL NAME Ralph F. Schilling
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White
6. (e) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Louise Schilling
6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased Jan. 6 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 8 22 hr. min.

9. Birthplace Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Stove Molder

11. Industry or business Retired

12. Name Ferdinand Schilling

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

14. Maiden name Unknown

15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Ed. Schilling

(b) Address 3727 Carter Ave.

17. (a) Burial (b) Date thereof 10-2-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Lebanon Cem.

18. (a) Signature of funeral director Drehmann-Harral

(b) Address 1905 Union Blvd.

19. SEP 30 1941 (b) J. P. Bredbeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 600
(c) City or town St. Louis 9 17
(If outside city or town limits, write "RURAL")
(d) Street No. 3727 Carter Ave. 9
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 28
year 1941 hour 6 minute _____ A. M.

21. I hereby certify that I attended the deceased from Sept 25 1941 to Sept 28 1941.
that I last saw him alive on Sept 28 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis with failure 5 yrs
chronic bronchitis 3 yrs
Duration

Due to _____

Due to _____

Other conditions Arteriosclerosis General
(Include pregnancy within 3 months of death)
Chronic Bronchitis

Major findings: Of operations none

Of autopsy none 930

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 J. J. J. J. J. (M. D. or other) 0

Address 607 N. Grand Blvd Date signed 9-29-41

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

MOTHER FATHER

P

12-3
Warren O. Carter
Class - 1st
Pm

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 Warren O. Carter
Licensed Embalmer No. 3534
P. O. Address.....

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.