V. S. No. 2
0M—1/47
Rev. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

1998

29482

State File No.

FILED SEP 2 1947 18

Registration District No.

Primary Registration District No.

Registrar's No. 7799

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

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: St. John's 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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4642a Wilcox
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME INFANT SCHILLER
3. (b) If veteran, name war None
3. (c) Social Security No.
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Aug. (Month) 13 (Day) 1947 (Year)

8. AGE: Years 0 Months 0 Days 2 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Infant
11. Industry or business
FATHER
12. Name Jack Schiller
13. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
MOTHER
14. Maiden name Jean Bosche
15. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
16. (a) Informant Jack Schiller
(b) Address 4642a Wilcox
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-16-47 (Month) (Day) (Year)
(c) Place: burial or cremation New St. Marcus Cem.
18. (a) Signature of funeral director Kriegshauser Und. Co.
(b) Address 4228 So. Kingshighway Bl.
19. (a) AUG 18 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 15 year 1947 hour 6:25 minute P. M.
21. I hereby certify that I attended the deceased from 8-13-47, 19, to 8-15-47, 19; that I last saw him alive on 8-15-47, 19; and that death occurred on the date and hour stated above.

Immediate cause of death: Atelectactic lung
Due to (autopsy - revealed
Due to lungs solid -
Other conditions (Include pregnancy within 3 months of death) microscopic
Major findings: to be done
Of operations later
Of autopsy (Dr Allen)

Duration

PHYSICIAN
Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following: St John Hosp.
(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? (Specify type of place)
While at work? (e) Means of injury
23. Signature O. C. Pfeifer M.D. (M. D. or other)
Address 4523 S Kings Highway Bl. Date signed 8/16/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 William O White

Licensed Embalmer No. 4291

P. O. Address 4228 So Kingshighway

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.