

FILED JAN 26 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2994

State File No. ....

318

1003

224

|  |                                  |  |  |  |   |  |  |
|--|----------------------------------|--|--|--|---|--|--|
| BIRTH NO. _____  |                                  | REG. DIST. NO. _____   |  | PRIMARY REG. DIST. NO. _____   |   | Registrar's No. _____  |  |
| 1. PLACE OF DEATH<br>a. COUNTY _____   |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>MISSOURI</u> b. COUNTY _____ |   |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <u>ST. LOUIS MO</u>  |                                  | c. LENGTH OF STAY (in this place)<br><u>10 DAYS</u>  |  | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <u>ST. LOUIS</u>                                   |   |  |  |
| d. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION <u>ST. ANTHONY'S Hosp.</u>   |                                  |  |  | d. STREET ADDRESS (If rural, give location)<br><u>3815 CONNECTICUT</u>   |   |  |  |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <u>VICTOR</u><br>b. (Middle) <u>E</u><br>c. (Last) <u>SCHILL</u>  |                                  |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>JAN. 10 1950</u> |  |   |  |  |
| 5. SEX<br><u>MALE</u>  | 6. COLOR OR RACE<br><u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>MARRIED</u>   | 8. DATE OF BIRTH<br><u>AUG. 1 1904</u>                       | 9. AGE (In years last birthday)<br><u>47</u>   | IF UNDER 1 YEAR<br>Months <u>5</u> Days <u>10</u> | IF UNDER 2 HRS.<br>Hours _____ Min. _____  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>PRESSMAN</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>POST-DISPATCH</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>ST. LOUIS MO</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                    |  |
| 13a. FATHER'S NAME<br><u>HENRY SCHILL</u>  |                                  | 13b. MOTHER'S MAIDEN NAME<br><u>ELIZABETH KAISER</u>   |  | 14. NAME OF HUSBAND OR WIFE _____  |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____   |                                  | 16. SOCIAL SECURITY NO.<br><u>488-10-9931</u>  |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><u>Josephine SCHILL 3815 CONNECTICUT</u>  |   |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma; etc. It means the disease, injury, or complication which caused death.  |                                  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Primary atypical pneumonia (Virus)</u><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>Aneurysm of aorta (Rupture)</u> |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>14 Days</u>                               |  |
| 19a. DATE OF OPERATION _____   |                                  | 19b. MAJOR FINDINGS OF OPERATION _____   |  |  |   | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____   |                                  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____   |  | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)<br><u>1492XB</u>   |   |  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____  |                                  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21f. HOW DID INJURY OCCUR? _____   |   |  |  |
| 22. I hereby certify that I attended the deceased from <u>Jan 1</u> , 19 <u>50</u> , to <u>Jan 10</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>Jan 11</u> , 19 <u>50</u> , and that death occurred at <u>1:30 p. m.</u> , from the causes and on the date stated above. |                                  |  |  |  |   |  |  |
| 23a. SIGNATURE (Degree or title)<br><u>Ed. Hoffmann M.D.</u>   |                                  |  |  | 23b. ADDRESS<br><u>16 Hampton willows Plaza</u>  |   | 23c. DATE SIGNED<br><u>1/12/50</u>   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |                                  | 24b. DATE<br><u>JAN 13 1950</u>  |  | 24c. NAME OF CEMETERY OR CREMATORY<br><u>NEW ST. MARCUS</u>  |   | 24d. LOCATION (City, town, or county) (State)<br><u>ST. LOUIS MO</u>             |  |
| DATE REC'D BY LOCAL<br><u>JAN 12 1950</u>  |                                  | REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>Thomas Kutis</u>  |   | ADDRESS<br><u>2906 Grand</u>   |  |

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

16  
No. 2854 10-11  
No. 4535 No. 3643

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 \_\_\_\_\_

..... Student Embalmer No. ....  
working under my personal supervision.

Signed James C. Hill

Signed .....  
Student Embalmer

Licensed Embalmer No. 4347

P. O. Address 2906 Davis

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.